



## Authorization for Release of Protected Health Information

I authorize: \_\_\_\_\_  
(Name of Primary Care Physician/Specialist)

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

*Please release my medical information to:*

Texas Laparoscopic Consultants

ATTN: Sherman C. Yu, MD

1200 Binz Street, #950

Houston, Texas 77004

Phone: (713) 493-7700

Fax: (281) 971-4065

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Service

The information to be released:

- Letter of Medical Necessity from Primary Care Physicians
- Letter and/or records from any Specialists with medical documentation
- Last three to five years of medical documentation with heights, weights, co-morbidities, medications, and family medical history
- Psychological Evaluation
- Nutritional Evaluation
- Recent EKG
- Recent lab work

*This information is being requested for approval of bariatric surgery.*

I understand that if the recipient authorized to receive the information is not a covered entity, for example, insurance company or non health care provider, the release of information may no longer be protected by federal and state privacy regulations.

To the party receiving the information, this information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness, Printed Name

\_\_\_\_\_  
Date