RESHAPED™
WEIGHT LOSS & WELLNESS

2008 E Hebron Pkwy, #114, Carrollton, TX 75007 • reshapedwellness.com • ph: 469.431.0544 • fax: 866.512.8083

Medical Records Authorization for Release of Medical Information

Patient Name: _____ Date: _____

Date of Birth: _____ SS#: _____ Phone: _____

Address: (Street) _____

City _____ State: _____ Zip: _____

BY STATE LAW YOU MUST BE ADVISED THAT: The information you authorize for release may include information regarding mental health, drug or alcohol use/abuse, communicable diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency virus also known as "AIDS".

I hereby authorize: _____

_____

_____

Phone: _____ Fax: _____

Release the following health record information of the above-named patient, for the following purpose:

❍ Insurance ❍ Medical ❍ Other: _____

The information to be released is: ❍ All Records ❍ History & Physical Exam ❍ Consultation

❍ X-Ray Reports ❍ Operative Reports ❍ Lab/Pathology ❍ Other: _____

The information is to be released to: RESHAPED™ Weight Loss & Wellness, PLLC

Address: 2008 E Hebron Pkwy, #114, Carrollton, TX 75007

Phone: 469.431.0544 Fax: 866.512.8083

This authorization will remain in force from the date of my signature until revoked upon written notification. Withdrawal of consent does not affect any information disclosed *prior* to the written notice of withdrawal. THERE MAY BE A FEE CHARGED FOR RECORD COPYING.

RE-DISCLOSURE: This information is being disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains.

_____ _____

Witness Signature Date Patient/Legal Guardian Signature Date