Disclosure of Health Information

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have received a Notice of privacy Practices from RWLAS. ______ (initial)

I hereby authorize the disclosure of my protected health information to the following non-healthcare related persons.

____
(Please Print)

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

I understand that the information I authorize a person or entity to receive may be re-disclosed and is no longer protected by federal privacy regulations.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment.

I understand that I may revoke this authorization at any time by notifying this physician's office in writing.

This authorization expires one year from date signed below.

______________________________ ______________________________
SIGNATURE OF PATIENT DATE

______________________________ ______________________________
PRINTED NAME OF PATIENT PATIENT'S DATE OF BIRTH

1280 E. Stearns St., Ste. 5, Fayetteville, AR 72703
www.rollerweightloss.com Ph 877.445.6460 Fx 479.445.6719