AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Dr. Joshua Roller Dr. Kristin Roller Dr. Yong Kwon
Dr. Jaime Dutton Dr. Noe Rodriguez Dr. Jessica Pries

_____

Patient's Name:

_____ _____

Social Security # Date of Birth

I request and authorize: Name: _____ Fax# _____

To release healthcare information of the patient named above to:

Roller Weight Loss & Advanced Surgery,
1695 E Rainforest Rd. Ste 2, Fayetteville, AR 72703 Fax: 479-445-6719
12112 Hwy 71 South, Fort Smith, AR 72916 Fax: 479-434-6354
3311 E. 46th Street, Tulsa, OK Fax: 918-970-6369

This request and authorization applies to:

- ○ Healthcare information relating to the following treatment, condition or dates:

_____

_____

- ○ All healthcare information
- ○ Other: _____

_____

Definition

I understand that my signature allows my medical information to be faxed or mailed to other physicians or insurance companies on behalf. A photocopy of this authorization shall be considered as valid as the original.

_____ _____

PATIENT/PARENT/GUARDIAN SIGNATURE DATE SIGNED

THIS AUTHORIZATION EXPIRES 12 MONTHS FROM THE DAY IT IS SIGNED.

ROLLER WEIGHT LOSS & ADVANCED SURGERY

1695 E Rainforest Dr. Ste. 2
Fayetteville, AR 72703
Ph 479-445-6460 · Fx 479-445-6719

12112 Hwy 71 South
Fort Smith, AR72716
Ph 479-434-6222 · Fx 479-434-6354

3311 E 46th Street
Tulsa, OK 74135
Ph 918-970-6366 · Fx 918-970-6369

www.rollerweightloss.com