Central Carolina Surgery, P. A.
1002 N. Church St., Suite 302
Greensboro, NC 27401
336 387-8100
Fax 336 387-8205

Standard Authorization of Use and Disclosure of Protected Health Information for Bariatric Surgery

To the patient: Please complete sections labeled "patient to complete" and return this form immediately to Central Carolina Surgery P. A., 1002 North Church Street, Suite 302, Greensboro, NC 27401. Obtaining records can sometimes take an extended period of time. We ask for your assistance by completing and returning this form promptly.

Patient to complete (Please print)

_____SS#_____Phone #_____ DOB _____
Patient Name (print)

_____
Street Address (print) City Zip

____ I do ____ do **NOT** authorize release of information related to AIDS or HIV Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Person/Organization to Whom Information May Be Disclosed
Information described below may be disclosed to:

Central Carolina Surgery, P. A.
Name of person/organization

1002 North Church Street, Suite 302	**Greensboro**	**NC**	**27401**
Street Address	City	State	Zip

Expiration Date of Authorization/ Right to Terminate or Revoke Authorization/ Potential for Re-disclosure
I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification to the Executive committee and Administrator of Central Carolina Surgery, but that it will not affect any information released prior to notification or cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or organization receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized may not condition its treatment of me on whether or not I sign the authorization.

_____
Patient's Signature Date

_____
Patient Representative's Signature Relationship

To the primary physician: This patient has been accepted into the Central Carolina Surgery Bariatric Program and has an appointment in our office on _____. Please have the patient's records sent prior to this date.

For physician use only – ALL Records requested for past 5 years to include, but not limited to the following:

- ❑ Discharge Summary
- ❑ Pathology Reports
- ❑ Emergency Reports
- ❑ History & Physical
- ❑ Lab Reports
- ❑ Office Notes
- ❑ Radiology Reports
- ❑ Operative Notes
- ❑ ECG/EEG/Cardiac Cath