



Authorization for Release of Medical Information

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Patient's Name: _____ Date of Birth: _____
Address: _____
City, State & Zip Code: _____
Social Security #: _____ Patient's Phone #: _____
Date of Request: _____ Date Needed: _____

I authorize Blossom Bariatrics to **release information to:**

OR

I authorize Blossom Bariatrics to **obtain information from:**

Name of Provider/Facility: _____
Address: _____
City, State & Zip Code: _____
Phone #: _____
Fax #: _____

Purpose for this request: Healthcare Insurance Coverage Personal
 Transfer of Care Other

Type of Records Requested:

- Immunization History
- All medical records related to a specific illness or injury:
Specify illness/injury: _____ Date(s) of treatment: _____
- Treatment summary (including history/physical, laboratory tests & x-ray reports, pathology)
- Specific information:
 - Procedure report History & Physical Physical Therapy X-ray reports
 - Laboratory test results Other: _____
- Copy of the entire medical record, as allowed by law.

Authorization Valid For:

- This request only
- One year from the date of this authorization **OR** _____. This authorization applies to the records of the treatment on or prior to the date of this authorization.

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at anytime by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information state above could be re-disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

Signature of Patient or Representative: _____ Date: _____
Relationship to Patient (if requester is not the patient): _____