

ECMOS PROLIFIC MEDICAL WEIGHT CARE

Optional / Complete only when requested

Specific records authorization

Use only when authorization is required or appropriate for the particular disclosure. HIPAA permits many treatment disclosures without an authorization; other laws can impose additional conditions.

Patient name / date of birth

Person or organization authorized to disclose / contact details

Specific recipient / address or approved destination

Specific records and date range (avoid an undefined all-records request)

Purpose of disclosure, or at the patient's request

Expiration date or event related to this purpose

My choice: I may revoke this authorization in writing by contacting the disclosing organization through its approved process, except to the extent action has already been taken in reliance on it. Treatment, payment, enrollment or eligibility generally will not be conditioned on signing this authorization, except as applicable law permits. Information disclosed may be redisclosed and may no longer be protected by HIPAA; other legal protections may still apply. I may receive a copy of the signed authorization.

Special records: This authorization excludes psychotherapy notes and records requiring additional consent under applicable law, including certain substance-use-disorder, HIV, genetic, mental-health and minor records. The office will arrange any additional permission required. It does not authorize marketing or testimonials.

☐ I authorize only the disclosure described above after questions and any special-record requirements have been addressed.

Patient / authorized representative signature / date

Representative authority, if applicable

Please ask questions before signing. Contact the disclosing office for secure delivery instructions and retain a signed copy.