



Release of Information

Appointment Date: _____

Innova Surgical Weight Loss Program

Release of Information: I authorize the release of any medical information necessary to Innova Hospital, to process this claim or provide medical information to any physician or medical facility.

Specific release for Mental health, drug or alcohol abuse or HIV information:

- 1) I hereby specifically authorize information that may include mental health, drug or alcohol abuse or HIV and related diseases, to release any and all information contained in my past or current medical records to the persons and organizations and for the purpose stated in Release of Information above.
- 2) By initialing the diagnosis(es)/condition(s) below, I do not consent to the release of such medical information, if any, to third party payors and understand I am personally responsible for payment.

Mental Health _____ Drug and Alcohol Abuse _____ HIV _____

Disclosure is limited to:

- No limitations placed on dates, history of illness, or diagnostic and therapeutic information.
- Records regarding admission and treatment for the following medical condition or injury:

- Records for the period (dates) from _____ to _____
- The following specified information:

- 1. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, except as provided in numbers 2 and 3 on this form.
- 2. If the purpose of this authorization is for an organization such as a health plan to life insurance company to determine eligibility before enrollment, the requested use or disclosure is not for psychotherapy notes and I refuse to sign this authorization. The organization reserves the right to deny enrollment of eligibility for benefits.
- 3. If the purpose of this authorization is to disclose health information to another party based on healthcare that is provided solely to obtain such information, and I refuse to sign this authorization, the Hospital or Clinic reserves the right to deny that healthcare.
- 4. I authorize that I may inspect or receive a copy of the information used or disclosed.
- 5. I understand that I may revoke this authorization at any time by notifying the Hospital or Clinic in writing, except to the extent that:
- 6. Action has already been take in reliance of the authorization or
- 7. If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself

Signature of patient or patient's legal authorized representative Date

Printed name of patient or patient's legal authorized representative

If you are signing on behalf of a patient for whom you are the legal authorized representative, you must attach a certified copy of your appointment as a legal authorized representative