Bariatric & Metabolic Health Center
Sarasota Memorial Health Care System
5880 Rand Blvd., Suite 211, Sarasota, Florida 34238
Phone: (941)917-4753 Fax: (941)917-4752

Patient Information & Authorization Sheet

Demographics

Patient Name: _____

Date of Birth: _____ Social Security #: _____

Home Address: _____

Home Phone: _____ can we leave a message on voicernai1? Y N with a person Y N

Cell Phone: _____ can we leave a message on voicemail? Y N

Work Phone: _____ can we leave a message on voicemail? Y N with a person Y N

E-Mail Address: _____

Can we communicate with you via email? Y N

Insurance Information

Insurance Carrier: _____

Identification #: _____

Group #: _____

Phone#: _____

Subscriber: _____

Relationship to Subscriber: _____

Primary Care Physician Information

Primary Care Physician: _____

Telephone #: _____

Fax #: _____

Pharmacy/#: _____

Release of Information

I hereby authorize Sarasota Memorial Health Care System (SMHCS) Bariatric & Metabolic Health Center to obtain/release my medical records to/from my healthcare providers throughout the course of my treatment and examination for the purpose of:

1) **Preoperatively** to obtain my records from my doctors that could include: PCP, Cardiologists, Pulmonologists, Endocrinologist, GYN, Urologist, Nephrologist, Gastroenterologist, Neurologist, and any other facilities if the records pertains to my health history and it demonstrates medical necessity for Bariatric Surgery.
2) **Preparation AND clearance for surgery** we use the form to refer patients to: Cardiologist, Pulmonologist, Psychologist / Psychiatrist, Endocrinologist, Hematologist, Nephrologist, and Gastroenterologist.

3) **Postoperatively** for Bariatric database tracking and medical/surgical follow-up care.

I hereby understand that this will include information relating to (initial if applicable):

_____ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
_____ Mental Health
_____ Treatment for alcohol and/or drug abuse
_____ Sexually Transmitted Disease

POSSIBILITY OF REDISCLOSURE: I understand that any information released may be subject to re-disclosure and no longer protected by state and federal regulations.

EXPIRATION AND REVOCATION: I understand that this authorization is valid for 24 months from the date I sign it and any photocopies or facsimiles of this form are valid as the original. I have the right to revoke this authorization in writing at any time. The revocation will take effect on the day it is received except to the extent it has already been acted upon or if the authorization was obtained as a condition of obtaining insurance coverage.

CONDITIONS OF TREATMENT: I understand that SMHCS Bariatric & Metabolic Health Center cannot condition treatment upon my signing this authorization.

_____ _____
Patient Signature Date

_____ _____
Signature of Witness Date