Madison Surgical Associates
General Surgery • Weight Loss Surgery Center
Ravindra Mailapur, MD, FACS
207 Longwood Drive Sw • Huntsville, Alabama 35801 • (256) 265-1890 • fax (256) 265-1891 • msahsv.com

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

ALL SECTIONS MUST BE COMPLETE

Information may be in paper or electronic form

Patient's Full Name: ______________________ SS Number (Optional): ______________________

Date of Birth: __________ Address: ____

Phone Number: ______________________ Date: ____________________

I authorize the use or disclosure of the above named individual's health information as described below:

1. Dr. Ravindra Mailapur and Madison Surgical Associates is authorized to make the disclosure.
2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ☐ **Office notes showing height and weight every six months for the last three to five years**

☐ Cardiac Stress Test results	☐ Colonoscopy results	☐ Last Mammography results
☐ Discharge Summary	☐ History and Physical	☐ Operative Note
☐ Pathology Report	☐ Consultation Report	☐ Office Progress Note
☐ EKG Report	☐ Outpatient Record	☐ Emergency Dept Record
☐ Laboratory Record	☐ Imaging Records	☐

3. I understand that the information in my health record may include information relating to sexually transmitted diseases acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. This information may be disclosed to, and used by, the following individual or organization for the purpose of General and Bariatric Surgery:
   Name: Ravindra V. Mailapur, M.D Address: 207 Longwood Drive SW, Huntsville, AL 35801
5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
6. Unless otherwise revoked, the authorization will expire on the following date, event, or condition: __________
   If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.
7. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations and that there is no guarantee that the electronic transmittal of this information can be securely and confidentially maintained.
8. I understand that I need not sign this form in order to ensure health care treatment, payment, and enrollment in my health plan or eligibility for benefits. Or
   I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
   Treatment Enrollment in the health plan Eligibility for benefits

Patient Signature: ______________________________ Date: ______________