James A. Davidson, M.D., F.A.C.S.
8210 Walnut Hill Lane #513
Dallas, Texas 75231
Attention: Cathy Davidson
214-696-2890
Fax: 214-373-6735

AUTHORIZED
RELEASE OF PROTECTED MEDICAL INFORMATION

FROM THE:
MEDICAL OFFICE OF: ______________________________
(Name of Physician sending records)

OFFICE #: ____________________ **Fax #:** ____________________

Please provide a copy of the medical records listed below by means of fascimile or mail for the person listed below to Dr. James A. Davidson, at the address or fax number listed on this form.

Patient: ____________________ **Date of Birth:** ____________________

Address: ____________________ **Last 4 digits of Social Security #:** ____________

City ____________ State ____________ Zip ____________

THE INFORMATION COVERED BY THIS AUTHORIZATION INCLUDES:

- [X] Most recent History and Physical by primary care physician
- [ ] Most recent CBC, CMP, LIPID, IRON, A1C, TSH, PTH
- [X] Records regarding weight loss attempts within the past 2 years including medications, behavior modification, with documented weight at each visit.
- [X] Documented weight for past 5 years (one chart note for each year showing weight)
  2010 2009 2008 2007 2006 2005
- [ ] Letter of Medical Necessity from treating physicians
- [X] Documentation of any other health conditions made worse by obesity
- [ ] Copy of previous operative report
- [ ] ____________________

I understand that I may revoke or terminate this authorization by submitting a written revocation to Dr. James Davidson. For any questions contact Cathy Davidson or Veronica Clark at 214-696-2890.

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's representative.

____
Signature of Patient

____
Signature of Patient Representative

____
Name of Patient (Printed)

____
Relationship of Representative to Patient

Date ____________________

Date ____________________