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NOBESO® Weight Program
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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient name: _____Date of birth: ____/____/_____
Address: _____ (City) _____ (State) ____ (Zip) _____

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure.*

Name: _____
Address: _____ (City) _____ (State) _____ (Zip) _____

1. The type and amount of information to be used or disclosed is as follows:
   - ☐ Complete health records
   - ☐ Physical exam
   - ☐ Immunization record
   - ☐ Lab results/X-ray reports
   - ☐ Consultation reports
   - ☐ Other (please specify): _____
2. I understand that the information in my health record may include information relating to sexually transmitted disease, 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.
   This information may be disclosed to and used by NOBESO® for the purpose of
   _____
3. 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 health information management department. 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
4. If I fail to specify an expiration date, event, or condition, this authorization will expire in 60 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact NOBESO®.

_____ _____
Patient's Name (printed) Witness

_____ _____
Patient Signature Date
(or signature of person with authority to consent for patient)