AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____ SSN: _____

Address: _____City: _____State: _____ ZipCode: _____

Telephone #: _____ Alternate Telephone #: _____

1. I authorize New Beginnings Surgical Group to disclose my medical record information and/or protected health information as described below.

2. The type and amount of information to be used or disclosed is as follows: (Please Check)

_X_ Entire Health Record _____ Operative Procedures _____ Lab Reports

_____ Progress Notes _____ X-ray/Imaging Reports _____ Other

3. I understand that the information in the Patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrom (AIDS), or human immunodeficiency virs (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to and used by the following individual(s) or organization(s):

Name: Kim Bariatric Institute

Address: 5204 Colleyville Blvd, Colleyville, Texas 76034

Phone: 817-581-6100 Fax: 817-581-3452

5. This information is being disclosed for the following purpose(s); Transfer of medical care

6. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to New Beginnings Surgical Group at which authorization was originally submitted. 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.

7. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: As Requested

If I fail to specify an expiration date, event, or condition, this authorization will expire six months from the date of signing.

8. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

_____ _____

Signature of Patient/Responsible Party or Legal Representative Date