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### RECORDS RELEASE

Date: \_\_\_\_\_

To: \_\_\_\_\_

Address: \_\_\_\_\_

**I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY MEDICAL RECORD (*OFFICE NOTES AND WEIGHTS*) IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT FOR THE LAST FIVE (5) YEARS. This information will be used to evaluate the patient for bariatric surgery and to obtain insurance precertification when necessary.**

TO: Surgical Association of Mobile, P.A.

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**PLEASE MAIL RECORDS TO:**

Surgical Association of Mobile, P.A.  
3 Mobile Infirmery Circle, Suite 212  
Mobile, AL 36607

**ATTN: Bariatric Precertification**

**DO NOT FAX RECORDS**

Patient: \_\_\_\_\_ (printed name)      DOB: \_\_\_\_\_

Signed: \_\_\_\_\_      SSN: \_\_\_\_\_

Relationship: \_\_\_\_\_      Our chart # \_\_\_\_\_

Witness: \_\_\_\_\_      Expiration: \_\_\_\_\_

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