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**GULF COAST BARIATRIC**  
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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.

- Jeffrey K. Hannon, M.D.
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**PLEASE MAIL RECORDS TO:**  
Surgical Association of Mobile, P.A.  
3 Mobile Infirmary Circle, Suite 212  
Mobile, AL 36607  
OR  
FAX #251-438-9607  
ATTN: Bariatric Precertification  
**DO NOT FAX MORE THAN**  
**25 PAGES**

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

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

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

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

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