



METABOLIC & BARIATRIC SURGERY OF FLORIDA | JOSEPH E. CHEBLI, MD

# NEW PATIENT REGISTRATION FORM

**Patient Name:** (first) \_\_\_\_\_ (last) \_\_\_\_\_ (m.i) \_\_\_\_\_

**Preferred Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Apt #:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Primary Phone Number:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Alternate Phone Number:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
[ ] Cell [ ] Home [ ] Work [ ] Cell [ ] Home [ ] Work

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_

**Sex:** [ ] Male [ ] Female **Social Security Number:** \_\_\_\_\_

**Marital Status:** [ ] Single [ ] Companion [ ] Married [ ] Divorced [ ] Widowed

**Patient Emergency Contact:** (first) \_\_\_\_\_ (last) \_\_\_\_\_

**Contact Number:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Relation to Patient:** \_\_\_\_\_

**Employment Status:** [ ] Full-Time [ ] Part-Time [ ] Unemployed [ ] Student [ ] Retired [ ] Other: \_\_\_\_\_

**Patient Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Primary Language:**

- English
- Spanish
- Russian
- Polish
- American Sign Language
- Other: \_\_\_\_\_

**Race:**

- American Indian / Alaskan Native
- Asian
- African American
- Hispanic / Latino
- Caucasian
- Prefer not to disclose

**Ethnicity:**

- Hispanic
- Non-Hispanic
- Prefer not to disclose

# INSURANCE INFORMATION

Who is to be billed for today's visit?

[ ] Insurance [ ] Self pay

<b>Primary Insurance Provider:</b> _____ <b>Policy Number:</b> _____ <b>Group Number:</b> _____ <b>Patient is Subscriber/Policy Holder:</b> [ ] Yes [ ] No	<b>Secondary Insurance Provider:</b> _____ <b>Policy Number:</b> _____ <b>Group Number:</b> _____ <b>Patient is Subscriber/Policy Holder:</b> [ ] Yes [ ] No
<b>Subscriber Information</b> (if other than patient) – <i>we will request to scan your ID and insurance card(s)</i> <b>Policy Holder Name:</b> _____ <b>Relation to Patient:</b> _____ <b>Address:</b> _____ <b>Date of Birth:</b> _____ <b>Social Security Number:</b> _____ <b>Employer:</b> _____ <b>Employer Contact Number:</b> _____	

# RELEASE OF INFORMATION

It is our responsibility to protect your medical records. We do not release any information regarding you or your medical conditions without your written consent. Please list below whom we can discuss your medical conditions, billing matters, and/or appointment schedule with.

<b>Name:</b> _____	<b>Contact Number:</b> (____) _____-_____	<b>Relationship to Patient:</b> _____	<b>Can Discuss:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Billing
<b>Name:</b> _____	<b>Contact Number:</b> (____) _____-_____	<b>Relationship to Patient:</b> _____	<b>Can Discuss:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Billing
<b>Name:</b> _____	<b>Contact Number:</b> (____) _____-_____	<b>Relationship to Patient:</b> _____	<b>Can Discuss:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Billing

Please mark which number we may call to leave messages. We often contact our patients for the reasons listed below:

<b>To confirm appointments:</b>	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Do not call / leave messages for this
<b>To report lab results / imaging studies:</b>	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Mail to home address <input type="checkbox"/> Do not call / leave messages for this

# INITIAL EVALUATION FORM

The following information is very important to the care of your health. Please take time to completely fill out this information to the best of your understanding.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

How did you hear about our practice?  
\_\_\_\_\_

What is your primary reason for making a bariatric consultation?  
\_\_\_\_\_

Are you seeking consultation of weight loss surgery for morbid obesity? \_\_\_\_\_

At what age did you develop a significant weight problem? \_\_\_\_\_

Are there events that are contributory to your weight gain? If so, please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever received treatment to lose weight?    [ ] YES                    [ ] NO

*If yes, please list what type:*

- Appetite Control Medications \_\_\_\_\_
- Restricted / Special Diet \_\_\_\_\_
- Surgery / Procedure \_\_\_\_\_
- Other \_\_\_\_\_

Record major diets that resulted in weight loss of 10lbs or more:

Year Started	Length of Diet	Type of Program	Starting Weight	Pounds Lost	How long did the weight stay off?

## Patient Care Team

1. **Primary Care Physician:** \_\_\_\_\_

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

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

2. **Cardiologist Name:** \_\_\_\_\_

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

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

3. **Gastroenterologist Name:** \_\_\_\_\_

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

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

# Pharmacy

1. Name of Pharmacy:

Address: \_\_\_\_\_ [ ] Mail Order Pharmacy

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

2. Name of Pharmacy:

Address: \_\_\_\_\_ [ ] Mail Order Pharmacy

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

## Allergies & Medications

Please list any known allergies and their corresponding reactions:

Agent / Medication	Reaction

Please list all prescribed and OTC medications, vitamins, and/or minerals that you are currently using:

Medication	Dose	Times per Day	Year Started	Purpose

## Previous Diagnostic Procedures

Please check any of the following diagnostic procedures that have been performed in *the last year* and indicate where we can retrieve them.

- EKG \_\_\_\_\_
- Stress Test \_\_\_\_\_
- Chest X-Ray \_\_\_\_\_
- Abdominal Ultrasound \_\_\_\_\_
- Echocardiogram \_\_\_\_\_
- Heart Cath \_\_\_\_\_
- Upper Endoscopy \_\_\_\_\_
- Upper GI Series \_\_\_\_\_
- Colonoscopy \_\_\_\_\_
- CT Scan \_\_\_\_\_
- Pulmonary Function Test \_\_\_\_\_
- Sleep Study \_\_\_\_\_
- Other \_\_\_\_\_

## Surgical History

Have you or a relative ever had bariatric surgery?     YES     NO

If yes, who? \_\_\_\_\_ Relationship: \_\_\_\_\_

If yes, what procedure? \_\_\_\_\_

If yes, by which surgeon? \_\_\_\_\_

Please list any surgical procedures you have had. Include the year performed and the reason(s) for the procedure(s). Please specify if the procedure was performed *laparoscopic* or *open*.

Surgery	Reason	Year	Laparoscopic / Open

# MEDICAL HEALTH INFORMATION

Please indicate if any of the following conditions have ever been significant problems for you. Please specify the year diagnosed and the physician who is currently managing the diagnosis.

## CARDIAC

**Coronary Artery Disease**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**MI (Heart Attack)**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Elevated Cholesterol**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Chest Pain**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Congestive Heart Failure**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Valvular Heart Disease**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Rheumatic Fever**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Heart Murmur**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Heart Arrhythmia**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**High Blood Pressure / Hypertension**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

## PULMONARY

**Asthma**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Pneumonia**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Bronchitis**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**COPD (Emphysema)**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Tuberculosis**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Diagnosed Sleep Apnea**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Obesity Hypoventilation Syndrome**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Pulmonary Hypertension**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

## ENDOCRINE

**Diabetes Mellitus**

**Yes**       **No**

**If yes, how is your Diabetes managed?**

- Insulin
- Oral medication
- Combination of both
- Neither

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Hyperthyroid**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Hypothyroid**

**Yes**     **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Adrenal (Cushing's)**

**Yes**     **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**GASTROINTESTINAL**

**Reflux Disease (Heartburn)**

**Yes**     **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Peptic Ulcer Disease**

**Yes**     **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Gallbladder Disease**

**Yes**     **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Liver Disease**

**Yes**     **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Inflammatory Bowel Disease**

**Yes**     **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Hiatal Hernia**

**Yes**     **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Irritable Bowel Syndrome**

**Yes**     **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**CANCER**

**Yes**     **No**

**Type / Organ Affected:**

\_\_\_\_\_

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_



## RENAL

**Kidney Disease**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Urinary Stress Incontinence**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Kidney Stones**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

## PERIPHERAL VASCULAR DISEASE

**Arterial Vascular Disease**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Pulmonary Embolism**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**DVT (Phlebitis)**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Superficial Phlebitis**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Peripheral Edema  
(swelling of legs/ankles)**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Leg Ulcers**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Varicose Veins**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

## CENTRAL NERVOUS SYSTEM

**Stroke**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Seizure**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Cerebral Aneurysm**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Arteriovenous Malformation**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Pseudo Tumor Cerebri**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Multiple Sclerosis**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

## PSYCHIATRIC DISORDERS

**Bipolar Depression**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Anxiety**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Schizophrenia**

**Yes**       **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Eating Disorder**

**Yes**       **No**

Type: \_\_\_\_\_

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

Are you receiving therapy or medications?

**Yes**       **No**

**Depression**

**Yes**       **No**

Severity:

Mild, no treatment

Moderate, with treatment

Severe, with intensive treatment

Severe, requiring hospitalization

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**MUSCULOSKELETAL DISORDERS**

**Gout**  **Yes**  **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Fibromyalgia**  **Yes**  **No**

*Treatment:*  exercise  Narcotic Medications  Non-Narcotic Medications  No Symptoms

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Abdominal Skin / Pannus**  **Yes**  **No**

*Symptoms:*  Irritation  Interferes with Ambulation  Recurrent Cellulitis and Ulceration  No Symptoms

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Functional Status Limited**  **Yes**  **No**

Requires Wheelchair  Able to walk 200ft with cane / crutch  Unable to walk 200ft without cane / crutch

**Lower Back Pain**  **Yes**  **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Osteoarthritis / DJD**  **Yes**  **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Osteoporosis**  **Yes**  **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Joint Pain**  **Yes**  **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Autoimmune Disease**  **Yes**  **No**

*Explain Further:*  
(Ex: Lupus, Rheumatoid Arthritis, Connective Tissue, etc.) \_\_\_\_\_  
\_\_\_\_\_

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

OBSTETRICAL/GYNECOLOGICAL

**Menstrual Irregularities**

- Yes**  **No**

Explain: \_\_\_\_\_

**Polycystic Ovarian Syndrome**

- Yes**  **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**History of Breast Cancer**

- Yes**  **No**

Year Diagnosed: \_\_\_\_\_ Physician: \_\_\_\_\_

**Indicate if you are**

- Pre-Menopausal**  **Post-Menopausal**

**Hysterectomy**

- Yes**  **No**

Year: \_\_\_\_\_

*How was it performed?*

- Vaginal**  **Abdominal**

*Were Ovaries removed?*

- Yes**  **No**

**Tubal Ligation**

- Yes**  **No**

Year: \_\_\_\_\_

*How was it performed?*

- Open**  **Laparoscopic**

**Number of Pregnancies to term:** \_\_\_\_\_

**Number of deliveries:** \_\_\_\_\_

SOCIAL HISTORY

**Occupation:** \_\_\_\_\_

- Full Time**  **Part Time**  **Retired**  **Disabled**

Please indicate cause: \_\_\_\_\_

What category best describes your highest level of education?

- High school**  **College**  **Graduate School**  **Vocational**  **Other**

What is your religious affiliation?

- Atheist**  **Christian**  **Catholic**  **Jehovah Witness**  **Jewish**  **Other**

**Do you have any children?**  **Yes**  **No**

If yes, how many? \_\_\_\_\_

**What are their names and ages?**

_____	_____
_____	_____
_____	_____
_____	_____

## TOBACCO / NICOTINE HISTORY

Do you currently use tobacco or nicotine products?  **Yes**  **No**

Have you ever used tobacco or nicotine products?  **Yes**  **No**

*What type?*

**Cigarettes**  **Vapor**  **Chew / Snuff**  **Cigar**

How many per day? \_\_\_\_\_

Start Age: \_\_\_\_\_

Stop Age: \_\_\_\_\_

Total years used: \_\_\_\_\_

## DRUG HISTORY

Have you ever used illicit drugs?  **Yes**  **No**

*What type?*

**Marijuana**  **Cocaine**  **Heroin**  **Amphetamine**

*How long ago?*

**Less than 5 months**  **6 months – 1 year**  **Over 1 year**

## ALCOHOL HISTORY

Do you currently drink alcohol?  **Yes**  **No**

*What type?*

**Wine**  **Beer**  **Liquor**  **Mixed**

*How many drinks do you currently consume?*

Daily: \_\_\_\_\_ Weekly: \_\_\_\_\_ Monthly: \_\_\_\_\_ Yearly: \_\_\_\_\_

Have you ever had a problem with alcohol abuse in the past?  **Yes**  **No**

Indicate how long: \_\_\_\_\_ Treatment: \_\_\_\_\_

*What type did you drink?*

**Wine**  **Beer**  **Liquor**  **Mixed**

## FAMILY HISTORY

In this section, please complete this chart to the best of your knowledge.

Has anyone in your family ever had a blood clot in their legs or lungs?

Yes

No

Has anyone in your family ever had a stroke?

Yes

No

Family Member	Deceased	Present Age	Medical Problems
FATHER	<input type="checkbox"/>		
MOTHER	<input type="checkbox"/>		
PATERNAL GRANDFATHER	<input type="checkbox"/>		
PATERNAL GRANDMOTHER	<input type="checkbox"/>		
MATERNAL GRANDFATHER	<input type="checkbox"/>		
MATERNAL GRANDMOTHER	<input type="checkbox"/>		
SIBLINGS	<input type="checkbox"/>		
	<input type="checkbox"/>		
CHILDREN	<input type="checkbox"/>		
	<input type="checkbox"/>		



# FINANCIAL POLICY FOR SURGERY

It is important for you to understand your financial obligations associated with your surgery. Please review the following and sign to indicate your understanding and acceptance of this responsibility.

1. Payment prior to routine scheduled office visits is expected. This is required by your insurance company contract. If co-payment cannot be made at the time of services, your appointment will be rescheduled to the next available time.
2. We will bill your insurance company for services rendered. Once insurance payment has been made and posted to your account, you will then receive a statement for any outstanding portion of the account (deductible).
3. *We appreciate payment in full within 10 days.* If payment cannot be made in full within 30 days of the first statement, you will be directed to our billing office to set up a payment plan. A payment plan may be established using:
  - a. Payments with a credit card.
  - b. Line of credit through a medical services credit company.
  - c. Establishing a monthly payment contract with our office.
4. Statements will be made monthly for outstanding balances. If the account is not paid in full or no payment has been received by the fourth statement, then the account may be forwarded to collections in accordance with the laws established by the state of Florida.
5. **Prior to elective surgery, we will confirm benefits and balances on deductibles with your insurance company. For your convenience, this will allow us to determine your portion of the bill prior to the procedure. Payment of this balance is required at the pre-operative appointment.**
6. Any questions or concerns regarding billing is to be addressed directly with the billing staff and *not* your surgeon.

*I am signing this document of my own free will. I understand my responsibilities for payment of the surgery, all related care, and costs associated with the surgery.*

---

(Patient Signature)

---

(Date)



# BARIATRIC PATIENT WEBSITE ACKNOWLEDGEMENT

I, *(patient printed name)* \_\_\_\_\_, acknowledge that I have reviewed the practice website: [www.MBSFLA.com](http://www.MBSFLA.com)

I have read detailed explanations on:

- ✓ Morbid Obesity
- ✓ Surgical Options for Treatment
- ✓ Benefits and Risks of Obesity Surgery
- ✓ Expected Weight Loss
- ✓ Surgical Techniques and Videos

\_\_\_\_\_  
*(Patient Signature)*

\_\_\_\_\_  
*(Date)*



METABOLIC & BARIATRIC SURGERY OF FLORIDA | JOSEPH E. CHEBLI, MD

## Authorization for Release of Information

\_\_\_\_\_  
*Patient Name*

\_\_\_\_\_  
*Date of Birth*

Please send information to:

Joseph E. Chebli, MD

**Phone:** (941) 209 - 4646

1370 E. Venice Avenue. Suite # 208

**Fax:** (941) 445 - 4152

Venice, FL. 34285

Information to be released:

- All medical records
- Specific information (Please specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Purpose for which disclosure is being made:** Continuity of care

### ***Patient Authorization:***

I understand that my records may contain information regarding the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give specific authorization for these records to be released.

**Exclude the following information from the records to be released:**

- Drug/Alcohol abuse, treatment, and diagnosis.
- Sexually transmitted disease
- HIV / AIDS diagnosis, treatment, and testing.
- Mental illness / psychiatric treatment.

### ***My Rights:***

I understand that I do not have to sign this authorization to obtain health care benefits, treatment, payment, or enrollment. I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person(s) or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

This authorization will expire 1 year from the date signed.

\_\_\_\_\_  
*(Patient Signature)*

\_\_\_\_\_  
*(Date)*