The Bariatric & Metabolic
WEIGHT LOSS CENTER
A subsidiary of Piedmont Family Practice

HIPPA RELEASE AUTHORIZATION REVIEW

Print Patient Name: ___________________________________ DOB: _____________________

Where may we leave a message, if any?
We will use the numbers listed on file, please verify with receptionist the numbers are correct.

Check all that apply	**Any applicable comments:**
Home	___________________________________
Day phone	___________________________________
Cell	___________________________________
Alternate	___________________________________

List any person we may speak to regarding your care:
If under 18, please list and indicate parent(s) or guardian(s):

(Blank implies no one)

Names	Relation
_____________________________	____________________________
_____________________________	____________________________
_______________________________	______________________________

If necessary, please list authorized person (s) to bring patient to appointments and their relation to the patient:

Names	Relation
_____________________________	____________________________
_____________________________	____________________________
_____________________________	____________________________

_______________________________   _____________________________
Patient or Guardian Signature   Date

493 Blackwell Road, Suite 118, Warrenton, VA. 20186
P: (540) 341-1728; F: (540) 341-2194
https://www.piedmontdocs.com/bariatric-weight-loss-center/