

FLORIDA LAKES SURGICAL



Acknowledgement and Consent

I, _____, consent to the release and use of my pictures and information related to weight loss, associated with Lap Band Surgery, to be used by Florida Lakes Surgical, PLLC, Florida Obesity Surgical Associates, and Highlands Obesity & Wellness Center for the purpose of advertisements, brochures, newspapers, websites, research, group meetings, and discussions.

I, _____, consent to the release and use of my medical chart, pictures, or information related to weight loss, associated with the Lap Band Surgery to be used by Florida Lakes Surgical, PLLC, Florida Obesity Surgical Associates, and Highlands Obesity & Wellness Center for the purpose to facilitate, expedite, and maintain the highest quality of care. Your medical record will be used by multiple people, including but not limited to the surgeon, nutritionist, physiatrist, bariatric coordinator, hospital, radiology, pathology, etc.

Signature of Patient or Legal Guardian

Date

Witness

Date

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