

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

To the Office of: \_\_\_\_\_

I hereby authorize you to release any information including the diagnosis and records of any treatment or examination rendered to me as follows: during the last five years that is related to:

*diet history, weight loss, pharmacy care and weight associated morbidities*  
*or*

\_\_\_\_\_ Primary care physician referral letter (see attached)

\_\_\_\_\_ Five year weight history (one page for each year from patient's chart which shows weight)

\_\_\_\_\_

to:

Dr. Russell Gornichec, M.D., P.C., F.A.C.S.  
3433 N.W. 56<sup>th</sup> Street, Suite 710  
Oklahoma City, OK 73112  
405-713-4450 Fax 405-713-4449  
(if over 10 pages please send by mail)

I understand this authorization is subject to revocation by me at any time except to the extent that action has already been taken in reliance on it. I understand that my medical records may contain information that indicates that I have a communicable or venereal disease, which may include but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as immune deficiency syndrome (AIDS). With this knowledge I give my consent to the release of all information in my medical records, including any information concerning my identity and release the above, its agents and employees from any liability in connection with the release of the information contained therein.

\_\_\_\_\_

Patient

\_\_\_\_\_

Date

\_\_\_\_\_

Witness

\_\_\_\_\_

Date