OVYVO
Medical Weight Loss

Request to Release Medical Information

Patient Name: _____ Date of Birth: _____

Primary Care Physician or Facility Information

For the purpose of coordination of care, I authorize the following medical facility to release my medical information to OVYVO Medical Weight Loss:

Current Doctor of Facility (if unsure, leave blank): _____

PCP Address: _____

PCP Phone: _____ PCP Fax: _____

Information to be Disclosed

(initial) Please release my records to OVYVO Medical Weight Loss Center for the purpose of coordination of care. This information should include:

_____

_____

Authorization

I may cancel this release at any time by notifying in writing the facility releasing records. I understand that any such revocation is not effective to the extent that action has been taken in reliance on this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by state or federal law. This release shall remain in effect until revoked in the above manner or for one calendar year.

Signature: _____ Date: _____

Witness: _____ Date: _____

Records may be submitted via fax: 717-889-0805