MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize and request you release my medical records to:

The Center for Medical Weight Loss
Dr. Passen
2360 W. Joppa Road – Suite 315
Lutherville, MD 21093
Telephone: (410)337-8446
Fax: (410)337-5580

Name of Patient: _____

Date of Birth of Patient:_____

Signature:_____