

GORDON RESEARCH INSTITUTE

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: (Physicians Name & Address) _____ DATE: _____

Reason for Request: _____

Fax # _____

Full Name of Patient: _____

Address: _____

Phone: _____ SSN: _____ - _____ - _____ Date of Birth: _____

LABORATORY

Date of Test: _____ Date of Test: _____

Date of Test: _____ Date of Test: _____

HOSPITAL

Date of Confinement: _____ Date of Confinement: _____

Date of Confinement: _____ Date of Confinement: _____

DOCTORS OFFICE

Date of Visit: _____ Date of Visit: _____

Date of Visit: _____ Date of Visit: _____

The undersigned hereby authorizes and consents that the all records relating to the condition and/or treatment of the aforementioned client be disclosed to wellness/nutrition coach - **Garry F. Gordon, MD, DO, MD(H)**, or any representatives of **Gordon Research Institute**, and all information, records, documents, reports, clinical abstracts, histories, notes and charts of every kind and description relating to the condition, care, confinement, and treatment of the above-indicated client and consent to the inspection and copying of same by them and to providing to them of photostatic or other copies of same. In furtherance of this authorization, we do hereby waive all provisions of law and privileges relating to the disclosures hereby authorized. A photostat form can be sent in lieu of the originals.

Date: _____

Patient Signature