Dr. Rogers
WELLNESS & WEIGHT LOSS CENTER
210-495-2117 • drrogerswellnessandweightloss.com

Authorization to Secure and Release Medical Information

I, ______________________________ hereby grant Dr. Rogers Wellness and Weight Loss Center permission to release or request information related to my care to the following providers:

	Physician Name	Phone #	Fax #
1.			
2.			
3.			
4.			
5.			

I understand that this release of information authorization shall remain in effect unless revoked by me at any time by submitting a written request to our office.

______________________________ ______________________________
Patient Name `   Date of Birth

____
Phone Number