# Authorization for Release of Medical Information

| *The undersigned hereby authorizes Clarkston Medical Group to release the following medical information on:* | | | |
|---|---|---|---|
| **Patient Name:** | | **Date of Birth:** | ___/____/_____ |
| **City, State, Zip Code:** | | | |
| **Home Phone:** | | **Business Phone:** | |
| *I authorize the following medical information may be used in the Clarkston Medical Group Weight Management Program Brochure.* | | | |

| | *Please check any and all that apply below:* |
|---|---|
| | Success story |
| | Name |
| | Picture |
| | Amount of weight lost |

This information is being released for the following purpose(s) only Weight Management Program Brochure and may not be used for any other purpose or released to any other person(s) without my written consent.

This release is permanent from the date of execution and only for the purpose designated above. However, it may be revoked at any time by providing notice in writing to Clarkston Medical Group.

_______________________________________________ ____/____/______
Patient Date

_______________________________________________ ____/____/______
Witness Signature Date

5701 Bow Pointe Drive Suite 100, Clarkston, Michigan 48346
Phone: 248-625-2621 Fax: 248-625-8939