



Frye Regional Medical Center
Surgical Weight Loss Program

Authorization for Medical Records Release

This information is for gathering purposes only. Once we have received all records, your chart will be forwarded to your surgeon's office. If you have any questions, please contact us at 828-315-5577.

Patient Information:

Name: _____ Date of Birth: _____

Address: _____

Name/Address/Phone Number of Entity to Release Information:

Entity Requesting Medical Records: Surgical Weight Loss Program
415 North Center Street, Suite 003
Hickory, NC 28601
828-315-5577-Phone
828-315-5950- Fax

Requested Information:

- Past 5 years medical records to include office visit notes with weights, recent Complete Physical and TSH.
 TSH CP Other _____

I authorize Surgical Weight Loss Program to request medical records for gathering purposes only. Once all records are received my chart will be forwarded to my surgeon's office. I certify that a copy of this release shall be valid as the original.

Signature of Patient: _____ Date: _____