

Endocrine and Diabetes Associates, LLC

*Patricia Petrick, MD FACP
Beatriz Chanduvi, MD FACE
Archana Shetty, MD
Anurag Gupta, MD
Yemul Almecci, MD*

*6430 Rockledge Drive, Suite 300
Bethesda, Maryland 20817
Phone 301-468-1451
Fax 301-468-3580
request@endocrinemd.net*

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize **Endocrine and Diabetes Associates, LLC**
6430 Rockledge Drive Ste 300 Bethesda, MD 20817

To provide medical records or a summary of the medical care of:

Name: _____

Date of Birth: _____

Social Security (*optional*) _____

To: _____

This authorization shall expire without my express revocation, one year from the date written below. I understand that I have the right to withdraw this authorization at any time, except to the extent that the action has been based on this authorization.

Signature of Patient or Guardian

Date