

Endocrine and Diabetes Associates, LLC

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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 or ID #: _____

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

Witness