***Endocrine and Diabetes Associates, LLC***

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

*6430 Rockledge Drive, Suite 300*
*Bethesda, Maryland 20817*
*Phone 301-468-1451*
*Fax 301-468-3580*
*medicalrecords@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:_____

Ph: _____

Fax: _____

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