

***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 Suite 300 Bethesda, Maryland 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