Endocrine and Diabetes Associates, LLC

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME _____

DATE OF BIRTH: _____

SOC SEC or ID # _____

I hereby authorize _____
(name of your doctor or facility)

FAX# _____

_____
(address)

_____

to furnish information from my medical records, to include history/exam, laboratory and/or radiology reports, and any information pertinent to my **appointment** provider at Endocrine and Diabetes Associates, LLC.

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 action has been taken on this authorization

_____ _____
Signature of Patient or Guardian **Date**