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**