

PALM BEACH DIABETES & ENDOCRINE SPECIALISTS, P.A.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby request and authorize PBDES (PALM BEACH DIABETES AND ENDOCRINE SPECIALISTS)

_____ RELEASE TO
or
_____ OBTAIN FROM _____

ADDRESS / FAX #

The following information:

_____ All medical information and reports _____ X-ray report(s)
_____ Thyroid scan and uptake _____ Ultrasound report(s)
_____ Laboratory report(s)

Except for the following which expressly may not be disclosed:

(If none write "None") _____

from the medical records of: _____
(Patient name)

SS# _____ DOB _____

All information I hereby authorize to be obtained from this physician/hospital/medical provider will be held strictly confidential and cannot be released by the recipient without my written consent.

I understand that this authorization will remain in effect for 90 days unless I specify an earlier expiration date here _____
Date

DATE SIGNATURE OF PATIENT/LEGAL GUARDIAN

DATE SIGNATURE OF WITNESS