Endocrine & Diabetes Center

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I request my confidential medical information to be released as I have identified below:

1. *Complete section A for medical records release **by** other entities **to** Endocrine & Diabetes Center.*
2. *Complete section B for medical records release **from** Endocrine & Diabetes Center **to** other entities.*

Patient Name: _____ Date of Birth: _____

Address: _____
(Street) (City) (State) (ZIP Code)
Approximate date(s) of treatment: _____ Phone # _____

___ All medical record ___ Operative reports ___ Pathology/Cytology report ___ Discharge summary

___ Laboratory findings ___ Radiology reports ___ Nuclear Medicine ___ Other: _____

This is for the purpose of:

___ Continuing medical care ___ Confirmatory consultation ___Other: Specify Reason: _____

SECTION A: I hereby authorize the following provider or organization to release the medical information of the above patient to Endocrine & Diabetes Center located at 301 Maple Avenue West, suite 120, Vienna, VA 22180
NAME OF THE PHYSICIAN/ORGANIZATION: _____

Address: _____
(Street) (City) (State) (ZIP Code)

SECTION B: I hereby authorize the release of medical information on above patient from ENDOCRINE & DIABETES CENTER to the following provider/organization:

Name of the physician/ Organization: _____

Address: _____Fax: _____

Note: There will be charge of $10 handling fee, 50 cents per page up to 50 pages and 25 cents per page after that.

Print Patient's Name: _____

Signature of Patient: _____ Date: _____

Signature of Legally Authorized Person: _____ Date: _____

Signature of witness: _____ Date: _____