

**MEDICAL RELEASE FROM
CAPITAL ENDOCRINE CARE, LLC, FAX: 855-592-1246**

DATE: _____

I, _____, DOB _____
LAST NAME, FIRST NAME

Social Security number: _____

Hereby authorize, CAPITAL ENDOCRINE CARE, LLC, to release my medical records and any information including the diagnosis, notes, test results, and records of any treatment or examination rendered to me during the period:

FROM: _____ TO: _____

TO: _____
Physician name and Practice name

Street Address

City State Zip code

Phone Fax

I understand that this authorization will be effective for one year. I understand that I may request to cancel this request with written notification. It will not affect any information released prior to notification of cancellation. I understand this authorization includes all medical records related to my treatment, including but not limited to consultations, examinations, test results, and treatment summaries. I acknowledge that the release of my medical records is subject to applicable laws and regulations governing the confidentiality of medical information. This information is intended for medical use. **NOTE:** all requests for printed copies may be charged at the rates established acceptable by Maryland State Law.

Signature: _____ Date: _____

Printed name: _____

