

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

DATE: _____

I, _____, DOB _____

LAST NAME, FIRST NAME

Social Security number: _____

Hereby authorize,

Physician name and Practice name

Street Address

City State Zip code

Phone

Fax

**TO RELEASE RECORDS TO:
CAPITAL ENDOCRINE CARE, LLC, FAX: 855-592-1246**

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.

Signature: _____

Date: _____

Printed name: _____

