AUTHORIZATION TO RELEASE INFORMATION

PATIENT INFORMATION	CORRESPONDING PHYSICIAN'S OFFICE
Patient Name: ______	Practice Name: ______
Male Female Age: ______ DOB: ______	Physician Name: ______
Home Phone: ______	Office Contact: ______
Cell-Phone: ______	Phone Number: ______
Address: ______	Street Address: ______
City, State, Zip: ______	City, State, Zip: ______
SS#: ______	Fax Number: ______
Drivers License State: ______ Number: ______	

I, ______________________________ authorize the release of my medical information
(Print Patient Name)

FROM TO

PENNSYLVANIA INSTITUTE OF ENDOCRINOLOGY, LLC
1575 Highlands Drive, Suite
206
Lititz, PA 17543
Phone: 717-568-8886 ● Fax: 717-627-2727

Indicate information requested:

Entire Record

Specific Information/Dates: ______________________________

Reason for Request: ______________________________

I understand that I might revoke this consent at any time in writing.

______________________ ______________________ __________
(Patient Signature) (Parent/Guardian: State Relationship) Date

For Office Use Only

Received: ______________________ Fee Paid: ______________________
Completed: ______________________