Midtown Endocrine Associates, PC
Authorization for Release of Medical Records

Patient Name____

Address____

Phone__________________________________

Date of Birth______________________ Last Four of Social Security________________

I authorize Midtown Endocrine Associates to SEND medical records to:

Send to (Name):____

Address____

City___________________State________Zip___________________

Fax#____

____ ____________________
Patient/Legal Representative Signature Date

____
Relationship to Patient

Midtown Endocrine Associates, PC
2200 N 3rd St, Phoenix, AZ 85004
Phone (602) 258-9955, Fax (602) 258-9933