Scottsdale Endocrinology

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Authorization to Release Medical Information to a Provider

I, _____ DOB _____ authorize the release of my health information, including my medical records, conditions, and / or treatment at Scottsdale Endocrinology **to the following provider.**

Name: _____

Phone _____

Fax _____

Specific Medical Records to Release: _____ Date _____

Radiology Reports: _____ Date _____

Please sign below that the patient agrees with the above authorizations.

Signature _____ Date _____