Rockland Endocrine & Diabetes Svcs. Authorization to Release Medical Records

Name of Patien	t		Date _			
	Date	e of Birth			٠.	
I, the undersigned, author	orize the relea medical	ase of, or request acces record(s) of the above	s to the infor named patie	mation specific nt.	ed below from the	
		ION TO BE RELEASEI EASE CIRCLE ALL TH		SSED:		
History 8	k Physical	Consultation Report	Emergen	Emergency Room Record		
Operative Reports		Discharge/Death Summary		Face Sheet		
Lab/Path Reports		(-Ray Reports/Images	oorts/Images Other:			
The above information may be	released (sp records are t	ecify name or title of the obe released and the a	e individual o ppropriate a	r the name of t ddress):	the organization to which	
		то:				
(Dantos III	posital Attor	ney, Insurance Compan	v Solf etc.)	Phone Nur	mher	
(Doctor, A	ospital, Altori	ley, insurance Compan	y, Seii, etc. <i>)</i>	Filone Nui	libei	
Address	(Street City	State and ZIP)		Fax Num	ber	
Address (Street, City, State and ZIP)				r ax rum	00.	
		FROM:				
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)) Pho	ne Number	Fax Number	
	Ad	dress (Street, City, Stat	te and ZIP)			
I understand that my records otherwise permitted by law disclosure by the recipient a include but is not limited	are confident v. Information nd no longer to history, dis	tial and cannot be disclo nused or disclosed purs protected. I understand	osed without suant to this that the spe ent of drug or	authorization n cified informati alcohol abuse	nay be subject to re- ion to be released may	
understand that I may revoke	this authoriza	ation in writing at any tir reliance upon the autho	me except to orization.	the extent tha	t action has been taken ir	
The authorization will expire	six (6) month	ns from the date of my s that time.	ignature, unl	ess I revoke th	ne authorization prior to	
Date:	Signatu	re:				
		Authorized Representat				