BAYAREA ENDOCRINOLOGY ASSOCIATES

DIPLOMATE AMERICAN BOARD OF ENDOCRINOLOGY, DIABETES & METABOLISM

4816 North Armenia Ave. Tampa 33603
PHONE: (813) 876-3636 | **FAX**: (813) 870-0077

2412 Cypress Glen, Suite #101. Wesley Chapel, FL 33544
PHONE: (813) 562-0342 | **FAX**: (813) 701-2474

CONSENT FOR RELEASE OF MEDICAL INFORMATION.

TO THE ATTENTION OF:

_____

_____

_____

Patient Last Name _____ First_____ MI_____

Address_____

City_____ State_____ Zip_____

Birth Date_____/_____/_____ Social Security # _____-_____-_____

_____

I HEREBY AUTHORIZE the above stated facility to release copies of my medical records to Bay Area Endocrinology Associates for the purpose of assisting in the care and treatment of my medical condition.
I AUTHORIZE release of information covering treatment dates of_____through and including_____.

I HEREBY RELEASE the said facility from any liability which may arise as a result of my authorization to release the foregoing records. This authorization covers all my medical records and treatments during the dates indicated.

_____ _____
Patient (or person authorized to consent for a minor or patient who is unable to sign due to a physical or mental incompetency) Date

_____
Witness