

**PALM BEACH DIABETES & ENDOCRINE SPECIALISTS, P.A.**

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**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I hereby request and authorize PBDES (PALM BEACH DIABETES AND ENDOCRINE SPECIALISTS)

\_\_\_\_\_ RELEASE TO  
or  
\_\_\_\_\_ OBTAIN FROM \_\_\_\_\_  
\_\_\_\_\_  
ADDRESS / FAX #

The following information:

\_\_\_\_\_ All medical information and reports      \_\_\_\_\_ X-ray report(s)  
\_\_\_\_\_ Thyroid scan and uptake                      \_\_\_\_\_ Ultrasound report(s)  
\_\_\_\_\_ Laboratory report(s)

Except for the following which expressly may not be disclosed:

(If none write "None") \_\_\_\_\_

from the medical records of: \_\_\_\_\_  
(Patient name)

SS# \_\_\_\_\_ DOB \_\_\_\_\_

All information I hereby authorize to be obtained from this physician/hospital/medical provider will be held strictly confidential and cannot be released by the recipient without my written consent.

I understand that this authorization will remain in effect for 90 days unless I specify an earlier expiration date here \_\_\_\_\_  
Date

\_\_\_\_\_  
DATE SIGNATURE OF PATIENT/LEGAL GUARDIAN

\_\_\_\_\_  
DATE SIGNATURE OF WITNESS