Doylestown Thyroid & Endocrine Associates, LLC

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RECORDS RELEASE AUTHORIZATION

To: _____
Doctor or Hospital

_____
Address

_____
Phone *Fax*

I hereby authorize and request you to release to:

Doylestown Thyroid & Endocrine Associates, LLC

103 Progress Drive, Suite 300

Doylestown, PA 18901

The progress notes, labs, radiology and pathology concerning my illness and/or treatment during the period from _____ to _____.

Name_____ DOB_____

Address_____

Signature_____ Date _____

(if relative, state relationship)