Endocrine & Metabolic Health Services

HORMONAL HARMONY FOR A BETTER YOU

# Authorization for Release of Medical Records to Endocrine & Metabolic Health Services,LLC

Date: ____________________

**Last name** **First name** **DOB**

**Address** **MRN**

**I authorize Dr Kiranjot Gujral to obtain from:**

**Doctor of hospital name** **Fax #**

**Address**

**I expressly authorize and consent to the disclosure of my health information related to (check all that apply):**

RECORDS REQUESTED: Please send only the most recent unless otherwise specified.

____ Progress Notes ____ Labs ____ MRI

____ DEXA ____ CT scan _____ X rays

Purpose of Disclosure: __ Medical Care __ Insurance __ Attorney __Other (specify) __________

I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. For the revocation of this authorization to be effective, the above name(s) or class of person(s) must receive the revocation in writing.
This authorization shall expire 6 months from the date signed. After 6 months, a new authorization form is needed. I understand this authorization is voluntary and may refuse to sign it.
I fully understand and accept the terms of this authorization. A copy of this authorization is valid as an original.

**Patient or authorized representative signature:** ______________________________ **Date:** ____________

**Patient or authorized representative name:** ______________________________