MEDICAL RECORDS RELEASE FORM

TO: _____

_____

(DOCTOR OR HOSPITAL)

I HEREBY AUTHORIZE YOU TO RELEASE ANY/ALL MEDICAL RECODS TO:

DIABETES AND ENDOCRINE HEALTH

DR. VIRAL J. SHAH

690 KINDERKAMACK RD, SUITE 201, ORADELL NJ 07649

TEL: (201) 483-7362 FAX: (551) 222-8130

www.diabetesandendocrinehealth.com Email: frontdesk@diabetesandendocrinehealth.com

PLEASE SEND THE COMPLETE MEDICAL RECORDS CONCERNING MY ILLNESS AND TREATMENT DURING THE PERIOD OF

FROM:_____ TO:_____

PRINT PATIENT'S NAME:_____

DATE OF BIRTH:_____ PHONE NUMBER:_____

SIGNATURE:_____

(PATIENT OR LEGAL GUARDIAN)

DATE: _____