

South Florida Endocrine Center

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION & LEAVE VOICE MAIL MESSAGE

Date: _____ Patient Name: _____

I give permission to release my medical records, information, samples, prescriptions etc. to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Is it ok to leave a detailed message on voice mail? _____

Patient Signature: _____