# Authorization for Release of Medical Records

**PATIENT INFORMATION (PLEASE PRINT):**

Name:_______________________________________________________________

Date of Birth:_________________ Social Security Number:___________________

Address:_____________________________________________________________

City:______________________________ State:_______ Zip:______________

Phone:______________________

**RELEASE MY MEDICAL RECORDS**

**FROM:** NeuroEndocrine Consulting LLC
Nancy Benzel, PA-C

**TO:** Name: ________________________________________

Telephone:_______________________________________

Fax:____________________________________________

Please release a copy of my medical records including:

_______History and Physical

_______Progress Notes

_______Lab Tests

_______Other Records:

_______Diagnostic Studies

_______Pap Smear (most recent)

_______Mammogram (most recent)

**BY MY SIGNATURE, I AUTHORIZE THE RELEASE OF MEDICAL RECORDS.**

________________________________________ Date:________________________

Patient (or Legal Guardian) Signature

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