NeuroEndocrine
CONSULTING

Authorization for Release of Medical Records

PATIENT INFORMATION (PLEASE PRINT):

Name:_____

Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____

RELEASE MY MEDICAL RECORDS

FROM: Name: _____

Telephone:_____

Fax:_____

TO: NeuroEndocrine Consulting LLC and Nancy Benzel, PA-C

Please send medical records no later than:_____

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)

For Past Patients of NeuroEndocrine Consulting (2007-2011)

_____I request that my Neuroendocrine Consulting medical chart be returned to Neuroendocrine Consulting and Nancy Benzel, PA-C.

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

_____ Date:_____

Patient (or Legal Guardian) Signature

Nancy Benzel, PA-C | **Office** (512) 540.4182 | **Fax** (512) 879.9046
3839 Bee Cave Road | Suite 202 | Austin, Texas 78746
NeuroEndocrineConsulting.com