Endocrinology Associates
OF PRINCETON, LLC

thyroid
diabetes
hormonal disorders
nutrition support

Authorization for Release of Medical Information

Patient Name: ____ DOB: __________________

Address: ____ Phone: _________________

____

To:

____
Name of Provider/Facility

____
Address

____
City, State, Zip Code

____
Phone # / Fax # (include area code)

I request and authorize you to send my medical records to **Endocrinology Associates of Princeton, LLC.**

TYPE OF RECORDS REQUESTED: (Check all that apply)
_ Laboratory reports___________________________
_ X-ray reports _______________________________
_ Complete Medical Record
_ Other (please specify) ____
____

PURPOSE FOR THIS REQUEST: ____

Please send information by fax or mail to:
Endocrinology Associates of Princeton, LLC **(609)924-4433**
601 Ewing Street, Suite C-8 **Fax (609)924-4423**
Princeton, NJ 08540

___________________________________ ___________________________
Signature of Patient Date