BOYNTON BEACH ENDOCRINOLOGY, P.A.
10150 HAGEN RANCH ROAD, SUITE 201
BOYNTON BEACH, FL 33437

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize _____ to

release healthcare information of the patient named above to:

Name: **BOYNTON BEACH ENDOCRINOLOGY**

Address: **10150 HAGEN RANCH ROAD, SUITE 201**

City: **BOYNTON BEACH** State: **FL** Zip Code: **33437**

This request and authorization applies to:

☐ LABS ☐ ULTRASOUNDS ☐ CT SCANS ☐ MRI

☐OTHER:_____

Treatment dates or ranges of dates of service to be released: _____

Patient Signature: _____ Date Signed: _____

(If not patient, indicate relationship): _____

Witness: _____ Date Signed: _____