Records Release/Request

To _____
(Doctor/Hospital)

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

I hereby authorize the release of my **most recent labs, tests and notes** or copies of such and request that they be transferred to:

Endocrinology Associates, Inc.
Elena A. Christofides MD, FACE
72 West Third Avenue
Columbus, Ohio 43201
Telephone: 614-453-9999
Fax: 614-453-9998

_____
Name of Patient (please print) Date of Birth/SSN

_____
Patient Signature Date

Clear all form fields.