



## Medical Record Release Form

I authorize the release of any information including diagnosis, Pharmacy information, Labs, medical records, examination rendered to me and claims information.

Medical records

Labs

Op reports

Imaging reports or Disc

All healthcare information

I release West Valley Endocrinology, Diabetes and Metabolism Center, its employees, agents, medical staff members and business associates from any legal responsibility for the disclosure of the information noted above to the extent indicated and authorized herein.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_\_\_