

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.

Dr. Elena A. Christofides M.D., F.A.C.E.

72 West Third Avenue

Columbus, Ohio 43201

(614) 453-9999/(614) 453-9998-fax

Print Name of Patient _____ Date of Birth/SS # _____

Patient Signature _____ Date _____