ENDOCRINE ASSOCIATES OF FLORIDA, P.A.

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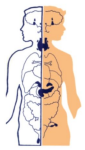

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize and request release of the following:

___ A copy of the most recent doctor notes, laboratory results, imaging.

___ Complete chart including reports, laboratory results, imaging, and medication.

MEDICAL RECORDS FROM:
Name of facility/person
to receive information from: _____

Address: _____

City, State, Zip: _____

Phone and Fax: _____

RELEASE MEDICAL RECORDS TO:
Name of facility/person
to receive information: _____

Address: _____

City, State, Zip: _____

Phone and Fax: _____

TO RECEIVING PARTY: The information is disclosed to you from records whose confidentiality is protected by law. Re-disclosure is prohibited without the written permission of the patient/client/legal representative listed above.

TO REQUESTING PARTY: I understand signing this document releases Endocrine Associates of Florida, P.A., from all legal responsibility and/or liability arising from the release of such records. Florida Statute has established guidelines and cost rates for copying of medical records. Your signature indicates your knowledge of this statement.

NOTE: PATIENT/REPRESENTATIVE MUST INITIAL APPLICABLE AREAS FOR RELEASE.

Psychiatric/phychological information _____(Initials)
Alcohol/drug/chemical information _____(Initials)
HIV tests and information pertaining to tests/treatment _____(Initials)

Patient's Name (printed): _____ Date: _____ Address: _____

SS# _____ DOB _____

Patient/Guardian Signature: _____ Account # _____

Witness Signature: _____ Date: _____