MEDICAL RECORD REQUEST and AUTHORIZATION

Date: _____

Dear Dr. _____,

This letter serves as my request and authorization for you to provide a copy of my medical records as they relate to endocrinology and related illnesses to:

___ Michelle D. Welch, MD

___ Daniel Katselnik, MD

___ Dorota Malinowski, MD

I am making this request so that *Diabetes and Metabolism Specialists* can provide me with specialty endocrine care from this point onward.

My information is as follows:

Name: (Last)_____(First)_____(MI)_____

DOB: _____/_____/_____

Mo Day Year

Address: _____

(Street Number) (City, State, Zip Code)

I appreciate your assistance with this matter:

Sincerely,

_____

(Patient/Legal Guardian Signature)

4118 Pond Hill Rd Bldg. #3 Shavano Park, TX 78231

Phone (210) 494-3737 Fax (210) 494-4508