Children's Endocrinology & Diabetes Center

RELEASE OF MEDICAL RECORDS

I hereby authorize _____ to release medical
(name of facility/person whom records are requested)

records relating to my child _____ DOB: _____ to

Dr. Anil Piya or one of his associates employed by the medical practice at **Children's Endocrinology and Diabetes Center, 310 Eisenhower Dr Ste 16, Savannah, GA 31406** via **Fax at 912-357-6002** and/or mail.

Please call the office at 912-357-6001 for any questions.

- ☐ All Records
- ☐ Progress Notes Only
- ☐ Bone Age X-ray Images and Reports
- ☐ Lab Reports Only
- ☐ Lab and Imaging Study Reports
- ☐ Study Reports Only

_____ _____

Parent/Legal Guardian Name and Signature Date