Arizona Endocrinology Center

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RELEASE OF RECORDS

I, _____, authorize _____ to release a copy of: (please circle one) all my records lab reports pertaining to my case to:

Name _____
Address _____
_____
Phone # _____
Fax # _____

Patients – do not mark this box, unless you want a copy of your medical records for yourself, as there is a fee.

☐ I am requesting a copy of medical records for myself. I understand that there will be a $15.00 fee which must be paid prior to mailing or at the time of pickup. Turnaround time for record requests is 5-7 business days. Arizona Endocrinology Center does not release copies of records received from other healthcare providers.

____ Mail to patient ____ Patient to pick up
____ Fax to above listed name ____ Mail to above listed name

____ Original ultrasound pictures given to patient. Patient is responsible for returning pictures to our office.

_____
Patient Name (**please print)**

Date:_____DOB:_____

_____
Patient's Signature

Do you plan to follow-up with our office? Yes No

Please allow 5-7 business days.