

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 time of pickup. Turnaround time for record requests is 5-7 business days. Arizona Endocrinology Center does NOT release records received from other healthcare providers.**

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

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.