CHANDLER ENDOCRINOLOGY

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Authorization To Release Healthcare Information

Patient Name: _____Date Of Birth: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

Please Specify Which Records Are Needed: _____

I, the undersigned, do hereby authorize and direct you to:

☐ Furnish records **TO** Chandler Endocrinology from:
☐ Release records **FROM** Chandler Endocrinology to:

Name: _____
Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

Purpose of Disclosure:

☐ Continuity of Care
☐ Second Opinion
☐ Changing Providers
☐ Other: _____

Please mark how records are to be released: Mail ☐ Fax ☐ Pick-Up ☐
(IF ALL RECORDS ARE REQUESTED, CHANDLER ENDOCRINOLOGY, WILL NOT FAX RECORDS)

*****Important Notice:** Per Practice Policy, We will **ONLY** print, mail or fax Chandler Endocrinology records. We DO NOT copy, print , mail or fax other Doctor's medical records. Please contact your previous Dr for these records.******

I understand that my request will processed within the 3 week timeframe set forth by AZ A.R.S. § 32-1401(27)(rr). I understand that I am responsible for the cost of copies
A copy of this authorization is as valid as an original and will expire 6 months from the date signed below.

Medical Records Request Fees:

- **PRINTED-** I understand that there will be a fee of $25.00 if I request my chart for personal use.
- **OVERSIZED DOCUMENTS-** I understand there will be a fee of $35.00 if I request my entire chart and it exceeds 100 pages.
- **NO CHARGE-** Any records that are being released for the purpose of continuation of care to a designated physician.

I understand that Chandler Endocrinology does not release copies of records received from other Health Care Providers.

Signature of patient: _____ Date: _____

WHEN FAXING RECORDS PLEASE ONLY SEND WHAT IS REQUESTED. NOT THE ENTIRE CHART. WE WILL NOT ACCEPT MORE THAN 15 PAGES BY FAX. IF MORE THAN 15 PAGES EITHER MAIL THEM OR ARRANGE FOR PATIENT PICK UP. THANK YOU, CHANDLER ENDOCRINOLOGY