# ENDOCRINOLOGY ASSOCIATES

Print Form

9328 East Raintree Drive | Scottsdale, AZ 85260 | (602) 266-8463 | Fax: (602) 266-0122
(480) 963-3929

## TRANSFERS *FROM* ENDOCRINOLOGY ASSOCIATES

I hereby authorize Endocrinology Associates to release medical information contained in my medical records to:

_____
(NAME OF PERSON TO RECEIVE INFORMATION)

_____ _____ _____ _____
Address City State Zip Code

## TRANSFERS *TO* ENDOCRINOLOGY ASSOCIATES

I hereby authorize:

_____
(NAME OF PERSON TO RECEIVE INFORMATION)

_____ _____ _____ _____
Address City State Zip Code

to release all medical information in my files to:

Dr. _____

for the purpose of: _____

## AUTHORIZED SIGNATURE

I recognize that the information disclosed may contain information that is privileged and protected by law and I specifically consent to disclosure of such information. When expedient, I authorize the transmittal of records by FAX, if my records are FAXED, I relieve the doctors of Endocrinology Associates, P.A. of responsibility for any mistransmission and/or potential breach of confidentiality. I understand that transmission is being sent by a secured fax.

_____ _____
PATIENT NAME (PRINT) BIRTH DATE

_____
CURRENT ADDRESS

_____ _____ _____
PATIENT SIGNATURE Date WITNESS/PARENT/GUARDIAN SIGNATURE

THIS REQUEST EXPIRES 90 DAYS FROM ABOVE DATE.

Please send copies of the following:

- ☐ History _____
- ☐ Operative report/type operation _____
- ☐ X-rays: Type _____ Date taken _____ ☐ Reports _____
- ☐ Medications/Therapy _____
- ☐ Lab/path/EKG reports _____
- ☐ Other _____