

## Records Release Authorization

I \_\_\_\_\_  
(enter patient name here)  
authorize Orlando Diabetes and Endocrine  
Specialists to release my medical records

TO: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Fax # \_\_\_\_\_

Phone # \_\_\_\_\_

### What are we sending?

- The most recent visit notes, lab work
- Complete chart including reports and medications
- Highly sensitive material concerning psychiatry evaluations
- Other: \_\_\_\_\_

### FOR COPYING CHART

If we are faxing to another physician, the first copy is complimentary. Otherwise there is always a charge for printing and or mailing.

**\$1.00 per page up to 25 pages**  
**Over 25 pages, \$.25 per page**

A release authorization must be signed and paid before records can be sent. Mistakes will only delay the process.

**5 Working days are required for a complete chart**

Patient Name: \_\_\_\_\_

SS#: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_