



Southern Diabetes Care

Family Endocrinology Center

JAMIE L BREWER, APRN, MSN, FNP-C

NATALIE BRADSHAW, APRN, MSN, FNP-C

OLIVIA BURCH, APRN, MSN, FNP-C

TINA CHANDLER, APRN, MSN, FNP-C

Authorization for Release of Medical Records

Patient Name: _____

Date of Birth: _____

SSN #: _____

Address: _____

City, State, Zip Code: _____

Request Records From, Provider or Facility Name: _____

Phone #: _____

Fax #: _____

Send Records to:

Southern Diabetes Care, PLLC
Jamie L Brewer, APRN, MSN, FNP-C
2785 HWY 49S, Suite B
Florence, MS 39073
(P) 601-891-8657 (F) 949-561-5551

Information Requested:

Complete Medical Record

Lab Results (___ Days)

Chart Note(s) (___ days)

Discharge Summary/H&P

EKG/Imaging Reports

Consult Note(s)

Operative Report/Pathology Report

I hereby authorize release of the above referenced medical records and request the same to be provided to Southern Diabetes Care, PLLC via fax, mail, or courier services. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this consent allows the use and disclosure of my protected health information for treatment on my behalf. I understand that I may revoke this consent at any time before the information has been released. Unless revoked, this consent expires 1 year from the date below.

Patient/Guardian Signature

Date

Relationship to Patient (if not patient signature): _____