Dr. David L. McHenry II N.D. PLLC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information (Please Print):

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Release Medical Records To/From:

Doctor's Name: _____

Address: _____

Phone Number: _____ Fax: _____

Release My Medical Records To/From:

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Tucson, AZ, 85719
Phone: (520) 338-9663
Fax: (520) 366-3266
www.DrDavidMcHenry.com
D.McHenryND@gmail.com

Please release a copy of all my medical records, including but not limited to, progress notes, operative reports, imaging and laboratory results, and diagnostic tests.

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MY MEDICAL RECORDS.

Patient or Guardian: _____ Date: _____

Relationship to Patient: _____