Desert Wellness Center
Family Medicine Using Modern Science and Ancient Wisdom

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (PLEASE PRINT):

Name:_____ Date of Birth:_____

Address: _____

City:_____ State:_____ Zip:_____

Phone #:_____

RELEASE MY MEDICAL RECORDS FROM:

Doctor's Name:_____

Address:_____

Phone #:_____

Fax #:_____

RELEASE MY MEDICAL RECORDS TO:

☐Spice A. Lussier, NMD ☐ Kiera J. Smialek, NMD

☐Courtney E. Cronin, NMD ☐ Barbara X. Ezrre NMD

Desert Wellness Center
2129 E. Warner Rd, #104
Tempe, AZ 85284

Phone: (480) 361-5188
Fax: (480) 304-3208

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

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient or Representative:_____ Date:_____

Relationship to the Patient: _____