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 TO/ FROM:

Doctor's Name: _____

Address: _____

Phone #: _____

Fax #: _____

RELEASE MY MEDICAL RECORDS TO/ FROM:

☐Spice A. Lussier, NMD ☐Courtney E. Cronin, NMD ☐Emilee Wayne, NMD

☐ Barbara X. Ezrre NMD ☐Kris Wallace, NMD

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2141 E. Warner Rd,
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: _____