



REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE: _____

TO: _____
(Name of Hospital or Physician)

PATIENT: _____
(Print or Type)

Street Address

City, State, ZIP Code

Dear Doctor:

I authorize you to forward medical information in your records regarding my evaluation/treatment to the physician office listed below. Please forward this information as promptly as possible. Thank you for your assistance.

Patient Name: _____ D.O.B. _____

Social Security Number: _____

Authorized Signature: _____ Date: _____

Send records to:

**ARIZONA PAIN MANAGEMENT & REHABILITATION
ESTELLE R. FARRELL, D.O.
DESERT COVE, SUITE 103
SCOTTSDALE, AZ 85260
Phn: (480) 659-2301
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