



# 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:

Dr. Courtney Cronin, NMD  
Desert Wellness Center  
44480 W. Honeycutt Rd, #107  
Maricopa, Az 85238

Phone: (520) 431-1080  
Fax: (520) 423-3001

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: \_\_\_\_\_