ARIZONA Weight Loss Solutions

Desert Ridge Medical Campus
20950 N. Tatum Blvd. | Suite 380
Phoenix, AZ 85050
Office: 480.419.2280
Fax: 480.419.2290
www.azwls.com

REQUEST FOR RELEASE OF MEDICAL RECORDS ☐ **To** ☐ **From**

NAME	John Husted, MD or Steven C. Simon, MD, FACS
ADDRESS	20950 N. Tatum Blvd. | Suite 380 Phoenix, Arizona 85050
PHONE	480-419-2280
FAX	480-419-2290

REQUEST FOR RELEASE OF MEDICAL RECORDS FROM

PHYSICIAN'S NAME _____

ADDRESS _____

_____

PHONE _____ FAX _____

I do hereby request and authorize release of my medical records to/from the above person. Please forward information concerning my medical care and/or treatment.

____ Operative Reports
____ Pathology Reports
____ Radiology Reports
____ History and Physical
____ Office Notes
____ Discharge Summary
____ Photos
____ **ALL RECORDS**

_____ _____

PATIENT SIGNATURE **DATE** **WITNESS SIGNATURE** **DATE**

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____

_____

PHONE # _____