Medical Records Release

Patient's Name: _____

Address: _____

_____

Date of Birth: _____

I, hereby, Authorize: _____

_____
Phone

_____
Fax

_____

_____
Address

To release my medical records via fax to:

Vuori Health Allergy &
Asthma Center

Phone: 928-224-2834

Fax: 1-928-240-5809

Address: 823 N. Beaver St.
Flagstaff, AZ 86001

Patient Signature: _____