



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

Phone: 928-224-2834

Fax: 928-436-2000

6 East Aspen Ave Suite 280

Flagstaff, AZ 86001

Attention: _____