125 Kallof Place Sedona, Arizona 86336
(928) 204-1942 • fax (928) 204-2128
info@sedonawellnessretreat.com

Sedona Wellness Retreat

I

Physician/Provider/Facility: _____

Address: _____

City:_____ State:_____ Zip: _____

Phone: _____

Fax: _____

REQUEST TYPE:	**OVER THE TIME PERIOD:**
☐ Lab & Imaging Reports	☐ Last Month
☐ Lab Only	☐ Last 6 Months
☐ X-Ray Only	☐ Last 12 Months
☐ Complete Medical Records	☐ Other _____

HEREBY AUTHORIZE AND REQUEST THE RELEASE OF INFORMATION CONCERNING MY HEALTH AND/OR TREATMENT.

These records or files shall include all confidential communicable disease-related information, confidential alcohol or drug abuse-related information and confidential mental health diagnosis/treatment information.

Patient Name:_____

Address: _____

City:_____ State:_____ Zip: _____

S.S.# _____ D.O.B:. _____

SIGNATURE: _____ DATE: _____