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NORTERRA
FAMILY MEDICINE

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Phoenix, AZ 85085

NorterraFamilyMedicine.com

MEDICAL RECORD RELEASE AUTHORIZATION

Patient Name: _____ DOB: _____

Records are being requested from the following office: _____

Phone: _____ Fax: _____

I, hereby, authorize the release of my medical records consisting of the following checked items:

_____ Lab Reports

_____ EKG Report(s)

_____ Recent Physical Exam(s)

_____ Operative Report(s)

_____ Radiologic Testing – X-Rays, Ultrasound, CT Scan, MRI Report(s)

_____ All Records from the Following Dates: _____

To be released to the physicians and staff of Norterra Family Medicine.

Fax #623.565.5061

Signature: _____ Printed Name: _____

Today's Date: _____