REPOWER
medical clinic

AUTHORIZATION FOR MEDICAL RECORDS REQUEST

Records to be sent TO:

Name: **Dr. Donese Worden, NMD**
Address: **3271 N. Civic Center Plaza #2 Scottsdale, AZ 85251**
Phone: **(480) 588-2233**
Fax: **(480) 588-2235**

Requesting records FROM:

Name:
Address:
Phone:
Fax:

Please release the following records:

- o Lab Reports
- o Operative/Path. Report
- o Gynecological Reports
- o Full Medical Report
- o Other

_____
Date of Service

_____
Date of Service

_____
Date of Service

_____
Date of Service

_____
Date of Service

Patient Name:

Patient's Date of Birth:

This consent will expire automatically SIX MONTHS from the date signed below.

Signature: _____Date: _____
Patient

Signature of Authorized Person: _____ _____
(Print) **(Signature)**

To be signed & returned to office if Patient authorizing release to other individual

Relationship to Patient: _____ **if the patient is a minor, the parent or legal guardian must sign.**