Arizona
OCULOPLASTIC
SPECIALISTS

REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ZIP:_____

TO: _____

DATES OF SERVICE: _____

I hereby request and authorize the release of my medical records to:

Arizona Oculoplastic Specialists
14275 N 87th Street
Scottsdale, AZ 85260
PH: 480 905–1010
Fax: 480 905-6988

Patient Sig: _____ Date: _____