**10405 N Scottsdale Rd, #3**

**Scottsdale, AZ. 85253**

**480-948-9000, Fax 480-659-0909**

# RECORDS RELEASE FORM

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office or fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to release a copy of my records to:

Dr. Christina Kovalik NMD, LAc., PLLC

# Fax 480-659-0909

I understand that by signing this release, my complete medical records will be sent to the above address. I have the authority to request Dr. Kovalik to send only specific parts of my records.

\_\_\_\_\_\_\_\_\_ History and Physical Exam

\_\_\_\_\_\_\_\_\_ Labs Only

\_\_\_\_\_\_\_\_\_ Complete records (History, Physical exam, and labs)

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_