STOUT WELLNESS CENTER

RE: Authorization to release medical records for _____

DOB: _____, SSN: _____

Doctor Name or Facility: _____

Street Address: _____

City: _____, State: _____, Zip: _____

Dear: _____

I am writing to authorize Stout Wellness Center to obtain my medical records on my behalf. Please release my medical records related to ALL treatment rendered by you or under your supervision.

Thank you for your consideration,

Patient Signature: _____ Date: _____

5130 Highway 95 Fort Mohave AZ 86426
Phone: 928-768-2811 Fax: 928-768-9787
Email: stoutchiro@gmail.com