10290 N 92nd Street, suite #300
Scottsdale, AZ 85251
www.azns.org
Phone: 480-718-9241 Fax: 480-718-9248

Authorization to Release Medical Records

Date: ______________________________

Name: ______________________________

Address: ______________________________
____
____

I hereby authorize Dr. Jose De Ocampo's Staff members to release ALL or PARTIAL Medical Records:

Complete Medical records: __________ Specific Records: ______________

Fax number:

NOTE: There will be a cost to print hard copy Medical Records
1. There will be a $15.00 flat fee as well as a $.25 per page for all request.
2. Please provide information of my Medical Records for dates: ______________

______________________________ ______________
Patient name (Please print) DOB:

____
Signature of Patient or Consenting or Consenting Individual