RECORDS RELEASE AUTHORIZATION

To: ____

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Please send the complete history records in your possession, concerning my illness and/or treatment during the period from ________________ to _________________.

Name: ____ Date: __________________

Address: ____

Signature: ________________________________ Relationship: ______________________
(if relative, state relationship)

Witness: __________________________________

Birth Date: ________________________________ Home Phone: ____________________

SSN: __________________________

Please send to:

444 W. Bourne Circle
Suite #200
Farmington, Utah 84025
Phone: (801) 776-0174
Fax: (801) 825-3904