RECORDS RELEASE AUTHORIZATION

To:	
The following information:	703 S Main St, Suite 8
☐ Complete Medical Record	Cottonwood, AZ 86326
☐ Lab Only	(928) 649-9234
□ X-rays Only	FAX 649-9334
Concerning my illness and/or treatment from	To
Name	Date
Address	
Date of birth	
Signature Witness	sed by
RECORDS RELEASE AU	THORIZATION
То:	
To:	
To:	I
To:	I
To:	To: Cheryl Kasdorf ND, LLC
To:	To: Cheryl Kasdorf ND, LLC 703 S Main St, Suite 8
To: Doctor / Hospital Address	703 S Main St, Suite 8 Cottonwood, AZ 86326
To: Doctor / Hospita	703 S Main St, Suite 8 Cottonwood, AZ 86326 (928) 649-9234 FAX 649-9334
To: Doctor / Hospita	To: Cheryl Kasdorf ND, LLC 703 S Main St, Suite 8 Cottonwood, AZ 86326 (928) 649-9234 FAX 649-9334 To
To: Doctor / Hospita	To: Cheryl Kasdorf ND, LLC 703 S Main St, Suite 8 Cottonwood, AZ 86326 (928) 649-9234 FAX 649-9334 To Date
To:	To: Cheryl Kasdorf ND, LLC 703 S Main St, Suite 8 Cottonwood, AZ 86326 (928) 649-9234 FAX 649-9334 To Date