RECORDS RELEASE AUTHORIZATION

To: _____
Doctor / Hospital

_____
Address

I Hereby Authorize and Request You To Release To: **Cheryl Kasdorf ND, LLC**

The following information:
- ☐ Complete Medical Record
- ☐ Lab Only
- ☐ X-rays Only

703 S Main St, Suite 8
Cottonwood, AZ 86326
(928) 649-9234
FAX 649-9334

Concerning my illness and/or treatment from _____ To _____

Name _____ Date _____

Address _____

Date of birth _____

Signature _____ Witnessed by _____

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