Arizona Neurology and Sleep Center
www.azns.org

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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