Date: ________________

Release of Medical Records

Patient Name: ____________________________________ Date of Birth: __/__/____

Doctor/Provider: ____

Fax: (___) ___-____ Phone: (___) ___-____ Email: ___________________________

I am requesting that you provide copies of my medical records, as specified:
__ All medical records
__Records pertaining to a specific disease/diagnosis/treatment:
____
____

__Records generated between:
Start Date: __________________ Finish Date: __________________

Please send the records to:

Copper Valley Medical, LLC
Attn: Dr. Don Selvey, NMD
4955 S. Alma School Road, 10
Chandler, Arizona 85248
(602) 566-2015 – o
(602) 680-1025 - f

Secure Email: Info@coppervalleymedical.com

The records are requested within ______ days.

Signature: ____
Patient Signature Date

Thank you for your prompt response to this request.