Medical Records Request

Last Name:_____First Name: _____

DOB: _____

Please circle all the specific documents that apply to your request:

Clinical Notes	Progress Notes	History & Physical	Discharge Summary
Lab Reports	Urgent Care	Emergency Room	Doctor Consults

The above referenced patient is requesting that medical records be mailed to:

Wooten Healthcare Group
515 W Buckeye Rd #306
Phoenix Az 85003

Parent's
Signature_____
By signing, I authorize the physician below to release all necessary records to Wooten Healthcare Group.

Name of Physician/Medical Office:
_____

Address: _____ City_____ State_____

Zip_____

Office:(_____)_____ Fax Number:(_____)_____

If this confidential transmission has reached you in error please fax and state "error" so we can reprocess.