Office of Jack M. Wolfson DO, FACC
10585 N Tatum Blvd. Suite D-135
Paradise Valley, AZ 85253
office: 480.535.6844 fax: 480.535.6845
health@thedrswolfson.com

Record Release Authorization

To: ______________________ ❑ Doctor ❑ Hospital

Office: ( ) .... Fax: ( ) ....

Address: .... City: .... State: .... Zip Code: ....

I hereby authorize and request you to release to:

Wolfson Integrative Cardiology, LLC
Jack M. Wolfson DO, FACC
10585 N. Tatum Blvd, Suite D-135
Paradise Valley, AZ 85253

P: 480-535-6844
F:480-535-6845
Health@thedrswolfson.com

The following information:

Complete Medical Record or other ....

I authorize the release of photocopies of the following medical records and/or x-ray/scan files. Records or files shall include all confidential communicable disease-related information (as defined in ARS 36-661), sensitive information including HIV/AIDS/Genetic Testing, confidential alcohol or drug abuse-related information and confidential mental health diagnosis/treatment information. Concerning my illness and/or treatment from .... to ....

Name: .... Age: .... Date of birth: ...... / ...... / ......

Address: .... City: .... State: .... Zip Code: ....

Email address: ....

Signature: .... Date: ....

Witness: .... Date: ....