**Patient Request for Records**

**To:** _____

Address:_____

Phone: _____ Fax: _____ e-mail: _____

**From:** Patient Name:_____Date:_____

Patient Date of Birth:_____ Patient S.S.#:_____

I hereby authorize and request you to release my complete medical records (including x-rays, if any, and diagnostic reports, and all records which pertain to the history, diagnosis, treatment or prognosis of my condition including records of other health care practitioners contained in the records) in your possession concerning my illness and/or medical treatment at your facility.

Please release my complete medical records to Dr. Fred G. Arnold, N.M.D. at Scottsdale Regenerative Medicine & Wellness, 7595 East McDonald Drive Suite 100, Scottsdale, AZ 85250.

Phone: (602) 292-2978
Fax: (480) 219-8132

_____ Patient or Nearest Relative