
## AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Name of physician/facility: _____

Address: _____

_____

Phone: _____ Fax: _____

Name of physician/facility: _____

Address: _____

_____

Phone: _____ Fax: _____

***I hereby authorize and request the physician/facility(s) above release my records to:***

**East Scottsdale Medical Care**
Jeffrey J. Baird, M.D. – Tracey Drummond, M.D.

10565 N. 114th St., Suite 103
Scottsdale, AZ 85259
Phone (480) 621-3505
Fax (480) 621-3506

_____ DOB: _____
Patient Name

_____ Date: _____
Signature