REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE:_____

TO: Dr. Carolyn DeSalvo, Rain Shadow Integrative Medicine
346 N. Sequim Avenue
Sequim WA 98382
360-504-3243

I hereby request that my medical records be released to:

Physician's Name: _____

Address: _____

_____

Fax Number: _____

Patient's Name: _____

Date of Birth:_____

Address: _____

_____

PATIENT'S SIGNATURE:_____

Date signed:_____