Sonya M. Johnson ND
2535 W. Glendale Ave, Phoenix, AZ 85051
Phone: (408)-341-9400 Fax: 623-321-0219

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Today's Date: _____

Previous Name: _____ Date of Birth: _____

Address: _____City: _____ State_____ Zip_____

Phone Number ( )_____

To:_____
Doctor or Hospital

_____
Address

_____
Phone/Fax#

I request and authorize release to:

Sonya M. Johnson, NMD
2535 W. Glendale Ave, Phoenix, AZ 85051
Phone: (480) 689-3474 Fax: 623-321-0219

FOR THE PURPOSE OF:

_____ Appointment

MEDICAL RECORDS

_____Copy of all medical records of the last two years of treatment received
_____Copy of all Medical Records covering dates from: _____ to _____
_____Copy of most recent Progress Notes

I hereby release Sonya M. Johnson NMD from any and all responsibility for fulfilling the authorization request for release of medical information. I have given my consent freely, voluntarily and without coercion.

_____ _____
Patient Signature Date

_____ _____

Parent / Guardian Date