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5980 S COOPER RD, STE 1  
CHANDLER, AZ 85249  
PH:(480)704-3474 FAX: (888)221-2541

I, \_\_\_\_\_ (Full Name) authorize the offices listed below to release my medical records to Paper Cranes Healthcare. If there is any information I do not want released, I have listed it below.

Physician or group name we are requesting information from:

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Please send the following medical records for the patient listed below:

- Medical records from the past year
- Lab results from the past year
- Imaging from the past year
- Hospital records ( including labs, imaging)
- Other: \_\_\_\_\_

Please do not include the following records: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Guardian Name: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_

**Please send all records to Paper Cranes Healthcare. Our fax number is (888)221-2541.**