M. ANGELO TRUJILLO, M.D.
RODNEY A. ENGEL, M.D
MELISSA HAKES, NP
VINCENT HONAN, M.D.

Northern Arizona Gastroenterology, PC
77 West Forest Avenue, Suite 210
Flagstaff, AZ 86001
Phone: 928-773-2547 or 800-859-2547
Fax: 928-773-2548

Records Release Authorization

Patient Name: ______________________ DOB: ______________

Describe Records Requested:

____

Treatment Dates: From: ______________ **To:** ______________

I wish to obtain a copy of the requested records from

Northern Arizona Gastroenterology.

Please send my records to: ______________________

Address or fax information: ______________________

____

Phone Number: ______________________

Fax Number: ______________________

Patient Information:

Patient Signature: ______________________ **Date:** ______________

For the personal representative of the patient:

Print the name of the personal representative:

____

Relationship to the patient: ______________________ **Date:** ______________

I certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.

Signature of personal representative: ______________________

NOTE: This request expires one year from date of signing