VSC

MEDICAL | REHAB | WELLNESS

RECORDS RELEASE

Patient's Name: _____

Date of Birth: _____

I hereby authorize you to release all records and any images (x-ray, MRI, CT-scan, etc.) acquired during the course of treatment to Valley Spinal Care.

Please send all requested information to:

Valley Spinal Care
5533 E Bell Rd. #109
Scottsdale, AZ 85254
Fax: 602.788.4208

Patient Signature: _____

Date: _____

***Please send images to the address above by mail or courier.**

Please contact the office with any questions you may have regarding this request at 602.788.4200