

Records Release Request

Date: _____

I am requesting the following records to be released from the care of :

To: Dr Anne Christine Hicks, NMD

Labs only Labs/Progress notes Imaging and reports Mammogram/DEXA

Note: _____

Please send to the following FAX: (602) 324-5627

Patient info:

Name _____ DOB _____

Address _____

Signature _____

Dr Christine Hicks, NMD
Kharma Life Center
700 W Campbell Ave, Ste 1
Phoenix, AZ 85013
P: (602) 451-9098
F: (602) 324-5627