Raymond Psonak D.O.

255 Intervale Road, New Gloucester, Maine 04260
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MEDICAL RECORDS RELEASE AUTHORIZATION

TO: _____
(Physician, Hospital, or other)

ADDRESS: _____

CITY, STATE, ZIP: _____

PLEASE FAX/Mail/Email COMPLETE COPIES OF MY MEDICAL RECORDS TO:

Raymond Psonak D.O.
255 Intervale Road
New Gloucester, Maine 04260
FAX: 207-517-2619 (or) 757-315-8052
Email: records@ChelationMC.com

_____ _____
SIGNATURE AUTHORIZING RELEASE (Patient/Parent/Guardian) Today's DATE

_____
PATIENT'S PRINTED NAME

_____
PATIENT'S DATE OF BIRTH

This form should be mailed or sent by Fax immediately to your Doctor(s).

Apr 2018