HEALINGSPACE
medical center

Medical Records Release Authorization

I, _____, hereby authorize HealingSpace Medical Center to release my medical records to:

Name:

Fax Number:

Phone Number:

Records Requested (Thermography Report, Ultrasound Report, Labs, Medical Chart, Other - please describe):

Forwarding Office Information
Marilyn Mitchell, M.D.
2075 Foxfield Rd., Suite 102
St. Charles, IL 60174
Phone Number: 847-304-5526
Fax Number: 855-832-6557

Patient Information:

Patient Name:

Date of Birth:

Patient Phone Number:

Patient Signature Date