AUTHORIZION FOR RELEASE OF MEDICAL INFORMATION
TO: SUZANNE BENNETT, DO

OBTAIN INFORMATION FROM:

Physician Name: _____

Address: _____

City, State, Zip: _____

PHONE: _____

FAX: _____

___Changing Physicians **___Specialist Request**

___Insurance Request **___Parent/Legal Guardian's Copy**

___Moving Out of Area **___Other: _____**

RELEASE INFORMATION TO:

Suzanne Bennett, DO

18275 N. 59th Avenue, Building H, Suite 144

Glendale, Arizona 85308

Phone: 602-843-2300 **Fax: 602-843-2310**

Patient Information

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Birthdate: _____

Patient Signature: _____

Date signed: _____