



Telephone: (480) 483-0393
Fax: (480) 237-9473
tarlowknee@gmail.com

Scottsdale Location 8630 E. Via De Ventura Suite 105 Scottsdale, AZ 85258	Uptown Phoenix Location 4440 North 36th Street Suite 100 Phoenix, AZ 85018
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Request for Release of Medical Records
Have your records sent to Advanced Knee Care

Patient: _____ **DOB:** ___ / ___ / ___
Address: _____
SSN: _____ **Phone:** _____

I hereby authorize the release of my medical records to Advanced Knee Care.

My treating physician is Dr. Stefan Tarlow

Information needed:

Healthcare information relating to the following treatment, condition, or dates of treatment _____

All healthcare information on file

Patient Signature: _____ **Date:** ___ / ___ / ___