



John J. DeBarros M.D., F.A.C.S. ~ Michael J. Orris, D.O. M.B.A.

Medical Records Request

Physician Name: _____

Address: _____

Phone: _____

Fax: _____

Date: _____

I, _____, hereby authorize the release of all my medical records and test results, including HIV test results, in your possession regarding my illness and/or treatment for the period indicated.

- All available records
- Past 12 months
- From _____ to _____

*Please be sure to include ALL operative reports or the name of facilities where reports can be obtained.

Please send my records to:

Weight Loss Institute of Arizona
Attn: Medical records
1855 E Southern Ave
Tempe, AZ 85282
Fax: 480-446-7602

I release your physician and employees from liability for following this authorization and request. I understand that it may take up to 14 business days for completion of this transaction. The fees charged by this office are set by the Arizona State Board of Medical Examiners. The first request for Medical Records is at no charge. Subsequent requests will be assessed a fee.

(Patient Signature)

(Printed Name)

(Date of Birth)

(Social Security Number)