RAPHAEL MEDICINE & THERAPIES, PC
M. Kelly Sutton MD CA G76932
9801 Fair Oaks Blvd., Suite 300
Fair Oaks, CA 95628
916-671-1780
Fax 916-844-0083
info@raphaelmedicine.com

MEDICAL RECORDS RELEASE AUTHORIZATION

TO:_____

_____

FROM:
Patient's Name_____

Other names, aliases, surnames, etc_____

DOB : _____ Patient or medical record number if applicable_____

Patient Address: _____

I hereby authorize and request you to release to:

M. Kelly Sutton MD-- CA G76932
Raphael Medicine & Therapies
9801 Fair Oaks Blvd., Suite 300
Fair Oaks, CA 95628
Phone (916) 671-1780 Fax (916) 844-0083

☐ all medical records (including lab reports, H & P, etc) Dates of treatment_____to___

☐ confidential/sensitive material (e.g. counseling/psychiatric services) Dates of treatment_____ to

☐ other: _____

I hereby allow you to verbally communicate with Dr. M. Kelly Sutton MD regarding current and past treatment of my physical/mental health. Initials _____

This request is valid for the time period from this date until _____. **(one year from below date unless otherwise noted)**

Signature_____ **Date**_____