



6630 S. McCarran Blvd Ste A-3
Reno, NV 89509
(775) 828-2863 (Main)
(866) 571-0056 (Fax)

AUTHORIZATION FOR RELEASE OF PRIVATE MEDICAL INFORMATION

Physician name: _____

Patients name: _____ Date of Birth: _____

Patients phone #: _____

This is a request for release of:

- Physicians dictations for date (s): _____
- Procedure Notes
- Medical Records excluding: _____
- Other (please specify): _____
- _____
- All

I hereby request that my medical records be released to:

Name: _____

Relationship to patient: _____

How would you like these records?

- Pick up -- Person picking up: _____
- Fax -- Number: _____
- Mail
- Address: _____
- City/State/Zip _____

Signature: _____ Date: _____

Please allow up to 10 business days for your request to be complete

**** Excessive records may incur a fee ****