6630 S. McCarran Blvd Ste A-3

Reno, NV 89509

(775) 828-2873 (Main)

(775) 448-9453 (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): _____**
- ☐ **Radiology interpretation reports**
- ☐ **X-ray films only**
- ☐ **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: _____

<u>Please allow up to 3 business days for your request to be complete</u>

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