10521 Jeffrey's St Suite #220
Henderson, NV 89052
Phone: 702-733-8871 Fax: 702-733-2177
www.urgentcareclinicslasvegas.com

AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records by the organization or physician listed below:

Physicians or Facility Name: ____

Physicians or Facility Address: ____

Physicians or Facility Phone: ______________________________ ☐ **STAT**

Fax # of Physician or Facility: ______________________________

Reason for Records Release: ____

These records are to be sent to Santa Rosa Medical Center in Henderson at the address listed above.

Patient's Name:__________________________Date Of Birth: ________________

Address:______________________City:__________State:____Zip Code: ______

Social Security #:______________________Phone#:______________________

The type and amount of information to be disclosed is initialed as follows: (specify dates where appropriate)

_____X-Ray films (Specify type/date)
____Immunizations
____Most recent 3 years of Records
____Entire Medical Record
_____Substance and Drug Abuse, if any
_____AIDS/HIV, if any
_____Genetic testing, from date
____Psychological/psychiatric conditions, if any

Other: ____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

______________________________ ______________________________
Patients Name Today's Date

______________________________ ______________________________
Parent/Guardian/Representative Relationship to Patient