Las Vegas OB/GYN Women's Care
401 N. Buffalo Dr. #110
Las Vegas, NV 89145
Phone: 702-778-4000
Fax: 702-778-4001

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____ Date of Birth: _______________

Address:____

Phone #: ____ Soc, Sec. #: __________________________________

I Hereby authorize release of my medical records from:

____

Please release the following records to Las Vegas OB/GYN Women's Care:

☐ **Doctors Notes/Dictation**

☐ **Labs/Pap/Pathology**

☐ **X-Ray Reports**

For the purpose of: ____

Medical records may include confidential information related to communicable disease, alcohol or drug abuse, genetic information, blood, breath, or urine screens, and mental health diagnosis and treatment.

I understand

- I may revoke this authorization except to the extent that it has already been acted upon.
- Once this information is released it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization.

____ ____________________________
Patient or Personal Representative's Signature Date

____
Witness

This authorization will expire on ______________________(list date if any)

* PLEASE NOTE*

If we are forwarding information to another physician's office, we will do so as a courtesy; no charge. Address is needed.
If for personal use, pursuant to N.R.S. 629.061, please be advised that there is a fee of $0.60 per page.
Please provide a copy of your ID with your written request. Thank you.