



5701 WEST CHARLESTON BLVD, SUITE # 105 LAS VEGAS, NEVADA 89146
2920 N. GREEN VALLEY PKWY BLDG 3 SUITE # 313 HENDERSON, NEVADA 89014
5751 S. FORT APACHE, SUITE #110 LAS VEGAS, NEVADA 89014
702-818-2444 (w); 702-818-2440 (f)

MEDICAL RELEASE FORM

I hereby authorize the release of all my medical information relating to the treatment I have received. Please do not release any further information to any other person(s) without my consent.

RELEASE INFORMATION TO:

Name of Facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

PATIENT INFORMATION:

Patient Name: _____

S.S#: _____ D.O.B: _____

I understand that if records are released to me that pursuant to NRS 629.06 I will **be charged a fee of \$0.60 per page.**

Signature: _____

Date: _____

This message is a PRIVILEGED AND CONFIDENTIAL communication any may contain information that is exempt from disclosure under applicable law. If you are not the intended recipient, or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copy of the communication is strictly prohibited. If you have received this communication in the error, notify the sender immediately by telephone and destroy the original message.