



## Medical Records Release Form

DATE: \_\_\_\_\_

STAT Request ( )

TO: \_\_\_\_\_

FAX#: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

Please release ( ) All Medical Records ( ) Labs ( ) Radiology Reports ( ) All Doctor Consultation Notes  
on file to Dr. \_\_\_\_\_ at the following address:

( ) 7500 W. Smoke Ranch, #200  
Las Vegas, NV 89128  
(702) 233-0727  
(702) 233-4799 – FAX

( ) 7200 Cathedral Rock Dr., #180  
Las Vegas, NV 89128  
(702) 341-9000  
(702) 341-5864 – FAX

( ) 7150 W. Sunset Road, #201A  
Las Vegas, NV 89113  
(702) 233-0727  
(702) 385-4346 - FAX

( ) 4 Sunset Way, #B-6  
Henderson, NV 89014  
(702) 454-6226  
(702) 454-7290 – FAX

( ) 1701 N. Green Valley Pkwy, Bldg. #10-C  
Henderson, NV 89074  
(702) 896-9600  
(702) 896-9606 – FAX

( ) 9053 S. Pecos, #2900A  
Henderson, NV 89074  
(702) 735-8000  
(702) 735-4795 - FAX

( ) 8915 S. Pecos, #19A  
Henderson, NV 89074  
(702) 341-9000  
(702) 341-5864 - FAX

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date