

Las Vegas Urology

ADULT AND PEDIATRIC UROLOGY
DIPLOMATES, AMERICAN BOARD OF UROLOGY

MEDICAL RECORDS RELEASE

TO:

PATIENT NAME:

SOCIAL SECURITY #:

D.O.B.:

Please release all medical records that you have on file to Dr. _____.
Please send the records to address checked below:

NORTHWEST

Las Vegas Urology, LLP
2901 North Tenaya Way
Suite 100

Las Vegas, NV 89128
Tel: 702.233.0727
Fax: 702.233.4799

WEST OFFICE

Las Vegas Urology, LLP
7200 Cathedral Rock
Suite 180

Las Vegas, NV 89128
Tel: 702.341.9000
Fax: 702.341.5864

If you have any questions, please contact our office at the number listed above.

Patient signature: _____

Date: _____

Witness: _____