MEDICAL RECORDS RELEASE AUTHORIZATION

Med-Care Providers

4525 S Sandhill Rd Ste 103, Las Vegas, NV, 89121

Phone: 702.723.0303 | Fax: 702,723.0303 | Email: info@med-careproviders.com

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Patient Information:

- **Full Name:** _____
- **Date of Birth:** _____
- **Phone Number:** _____
- **Address:** _____

I hereby authorize the release of my medical records from:
Facility/Provider Name: _____
Phone: _____ **Fax:** _____
Address: _____

Please release the following information to:
Med-Care Providers
4525 S Sandhill Rd Ste 103, Las Vegas, NV, 89121
Phone: 702.723.0303
Fax: 702.723.0303

Information to be released (check all that apply):
☐ Complete Medical Records
☐ Office Visit Notes
☐ Lab Results
☐ Imaging Reports (X-ray, MRI, CT, etc.)
☐ Medication History
☐ Immunization Records
☐ Other: _____

Purpose of Request:
☐ Continuity of Care (New Patient Visit)
☐ Other: _____

Authorization:

I understand that this authorization is voluntary. I may revoke this authorization at any time by providing written notice to the facility releasing the information. I understand that revocation will not apply to information already released in response to this authorization. I understand that once my information is disclosed, it may be subject to re-disclosure and may no longer be protected by federal privacy regulations.

This authorization is valid for **one (1) year** from the date signed unless otherwise specified.

Expiration date (if different): _____

Patient Signature: _____ **Date:** _____

If signed by someone other than the patient, indicate your legal authority:

☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Other: _____

Printed Name of Representative (if applicable): _____