Sparks Family Medicine

653 Town Center Drive, Suite 514
Las Vegas, Nevada 89144
(702) 243-2689 Phone
(702) 243-2632 Fax

Medical Records Release 2 *(From SFM)*

(Name of Patient) (Birthdate)

(Street Address) (City, State, ZIP Code)

Authorizes:

(Name of Physician)

Sparks Family Medicine, Ltd.

653 Town Center Drive, Suite 514

Las Vegas, Nevada, 89144

(702) 243-2632 Fax (702) 243-2689 Phone

Release of Records to:

(Name of Physician)

(Name of Group/Entity)

(Street Address)

(City, State, ZIP Code)

(Fax) (Telephone)

Information to be Released:

- ⊂ **All Clinic Records** ⊂ Visual Fields ⊂ Allergy Records
- ⊂ Eye Records ⊂ X-Ray Reports ⊂ Lab Reports
- ⊂ Office Notes ⊂ Immunization Records ⊂ Electrocardiograms
- ⊂ Photographs ⊂ X-Ray Films (Specify): ____ ⊂ Other (Specify): ____

For the Following Dates: ____

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

- ⊂ Mental health ⊂ AIDS test results ⊂ Developmental disabilities
- ⊂ Drug abuse ⊂ Other: ____ ⊂ AIDS-related disease diagnosis
- ⊂ Alcoholism

Purpose or need for disclosure: (check applicable categories)

- ⊂ Further medical care ⊂ Payment of insurance claim ⊂ Legal investigation
- ⊂ Application for insurance ⊂ Personal ⊂ Other
- ⊂ Disability determination ⊂ Vocational rehabilitation evaluation

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice. (Alternate date if not one year): ____

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

Signature of Patient ____ Date ____

È(If signed by person other than patient, state relationship and authorization to do so)È

(Authorized signature) (Relationship)

Patient is: ⊂ Minor ⊂ Incompetent ⊂ Disabled ⊂ Deceased

Legal Authority: ⊂ Legal ⊂ Legal guardian ⊂ Next of kin of deceased