

Sparks Family Medicine, Ltd.

10785 W. Twain Ave., Suite 221

Las Vegas, Nevada 89135

(702) 722-2200 Phone

(702) 722-2201 Fax

Medical Records Release 2 (From SFM)

(Name of Patient)

(Birthdate)

(Street Address)

(City, State, ZIP Code)

Authorizes:

Release of Records to:

(Name of Physician)

(Name of Physician)

Sparks Family Medicine, Ltd.

(Name of Group/Entity)

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(Street Address)

Las Vegas, Nevada, 89135

(City, State, ZIP Code)

(702) 722-2201 Fax (702) 722-2200 Phone

(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 _____

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

(Authorized signature)

(Relationship)

Patient is:

Minor

Incompetent

Disabled

Deceased

Legal Authority:

Legal

Legal guardian

Next of kin of deceased