# Medical Records Release 1 (To SFM)

To: **Medical Records**

Fax: _____

Tele: _____

From: **Sparks Family Medicine, Ltd.**

410 South Rampart, Suite #390

Las Vegas, Nevada 89145

_____
Name of Patient

_____
Date of Birth

_____
Address

_____
City, State, ZIP Code

**Authorizes:**

_____
Name of Physician

_____
Name of Group/Entity

_____
Street Address

_____
City, State, ZIP code

**Release of Records to:**

Sparks Family Medicine, Ltd.
410 South Rampart, Suite #390
Las Vegas, Nevada 89145
Phone: 702-722-2200
Fax: 702-722-2201

**Information to be Released (circle all that apply):**

| | | | |
|---|---|---|---|
| **All Clinical Records** | Visual Fields | Allergy Records | Photographs |
| Eye Records | X-Ray Reports | Lab Reports | X-Ray Films (specify) _____ |
| Office Notes | Immunization Records | Electrocardiograms | 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 (circle all that apply):

| | | | |
|---|---|---|---|
| Mental Health | AIDS test results | Alcoholism | Other (specify) _____ |
| Drug Abuse | Developmental disabilities | AIDS – related disease diagnosis | |

**Purpose of need for disclosure (circle all that apply):**

| | | | |
|---|---|---|---|
| Further medical care | Personal | Vocational rehabilitation evaluation | Legal investigation |
| Application for insurance | Disability determination | Payment or insurance claim | Other (specify) _____ |

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 specification 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** (circle all that apply): | Minor | Incompetent | Disabled | Deceased |
| **Legal Authority** (circle all that apply): | Legal | Legal guardian | Next of kin of deceased | |