



**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

There will be a service fee of \$0.60 per page for medical records forwarded to a lawyer, insurance company, or directly to the patient. We will, however, transfer medical records to another physician at no cost.

I hereby authorize my Provider to release any information necessary for the course of treatment.

TODAY'S DATE: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_

PATIENT'S DATE OF BIRTH: \_\_\_\_\_

RELEASE THE FOLLOWING RECORDS TO:

INTERNAL MEDICINE SPECIALISTS  
201 N Buffalo Dr Las Vegas NV 89145  
TEL (702) 242-2737 • FAX (702) 255-3170

RELEASE THE FOLLOWING RECORDS FROM:

ORGANIZATION'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

- |                                               |                                                          |                                                 |
|-----------------------------------------------|----------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Entire Health Record | <input type="checkbox"/> Prescription List               | <input type="checkbox"/> Blood Sugar Result (s) |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Laboratory/Radiology Result (s) | <input type="checkbox"/> EKG                    |

\_\_\_\_\_  
PATIENT'S SIGNATURE DATE

\_\_\_\_\_  
AUTHORIZED REPRESENTATIVE'S SIGNATURE DATE

RELATIONSHIP TO PATIENT: \_\_\_\_\_