LAS VEGAS UROLOGY

Medical Records Release Form

DATE: _____ **STAT Request ( )**

TO: _____

FAX#: _____

Patient Name: _____

Patient Address: _____

DOB: _____ SS#: _____

Please release ( ) All Medical Records ( ) Labs ( ) Radiology Reports ( ) All Doctor Consultation Notes

on file to Dr. _____ at the following address:

( ) 7500 W. Smoke Ranch, #200
Las Vegas, NV 89128
(702) 233-0727
(702) 233-4799 – FAX

( ) 7200 Cathedral Rock Dr., #180
Las Vegas, NV 89128
(702) 341-9000
(702) 341-5864 – FAX

( ) 7150 W. Sunset Road, #201A
Las Vegas, NV 89113
(702) 233-0727
(702) 385-4346 - FAX

( ) 4 Sunset Way, #B-6
Henderson, NV 89014
(702) 454-6226
(702) 454-7290 – FAX

( ) 1701 N. Green Valley Pkwy, Bldg. #10-C
Henderson, NV 89074
(702) 896-9600
(702) 896-9606 – FAX

( ) 9053 S. Pecos, #2900A
Henderson, NV 89074
(702) 735-8000
(702) 735-4795 - FAX

( ) 8915 S. Pecos, #19A
Henderson, NV 89074
(702) 341-9000
(702) 341-5864 - FAX

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date