AUTHORIZATION AND CONSENT TO RELEASE MEDICAL RECORDS

I, _____Date of Birth _____ a patient of Alamo Medical Clinic, Hereby authorize the release of the following:

_____ Lab

_____ Diagnostic Testing

_____ Office Notes

_____ Hospital In-patient Stay

_____ Emergency Room Visit

_____ Urgent Care

Patient Name: _____

Signature of Patient: _____

Date: _____

Medical Records Request from the following Party:

Physician Name: _____

Name of Facility: _____

Telephone Number: _____

Facsimile Number: _____

Please send requested records to:

Alamo medical Clinic
56 N. Pecos Road, Ste A
Henderson, NV 89074
Telephone: 702-456-4011
Facsimile: 702-454-5224