Medical Records Release 1 (To SFM)

To: **Medical Records**

Fax: _____

Tele: _____

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

10155 W. Twain Ave, Suite #110

Las Vegas, Nevada 89147

_____ _____

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.
10155 W. Twain Ave, Suite #110
Las Vegas, Nevada 89147
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	