Release of Information Form

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I request and authorize the release of all my medical information relating to the treatment I may have received. Please do not release any further information to any person (s) without my consent.

This request and authorization apply to:

Patient's Name:	Date of Birth:
Previous Name:	

RELEASE INFORMATION TO:

Name of facility: **Vegas Gastroenterology**	
Address: **5701 W. Charleston Blvd. Suite # 201** **Las Vegas, NV 89146**	
Phone: **(702) 750-0313**	Fax: **(702) 487-3197**

Patient Signature: _____ Date signed:_____

I understand that if records are released to me pursuant to NRS 629.061, I will be charged a fee of $0.60 per page.

This message is a PRIVILIGE AND CONFIDENTIAL communication and may contain information exempt from disclosure under applicable law. If you are not the intended recipient or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please inform the sender immediately by telephone.