PLEASE SEND OR FAX THIS REQUEST TO YOUR LAST PHYSICIAN OR CLINIC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

TO: (name of hospital/facility/clinic/doctor)_____

FAX NUMBER:_____

MAILING ADDRESS: _____
_____
_____
_____
_____

I, _____hereby authorize the above mentioned medical facility/physician noted below to release any and all of my medical records, reports, lab reports to:

Farrukh Imtiaz, M.D.
Nevada Medical Clinic
4445 S. EASTERN AVENUE, SUITE B
LAS VEGAS, NEVADA 89119
TEL: (702) 933-6767
FAX: (702) 933-6770

Patient Name: _____

SSN: _____D.O.B. _____

PHONE#:_____

HOME ADDRESS: _____
_____
_____

Patients'/legal representative signature: _____

DATE: _____

KINDLY EXPEDITE AND FAX RECORDS ASAP!!!! THANKS IN ADVANCE FOR YOUR ANTICIPATED CO-OPERATION IN THIS MATTER.