REQUEST FOR RECORDS RELEASE

To Medical Records: _____

_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Fax Number: _____ Phone Number: _____

The following individual has asked us to request that his or her medical records be released and forwarded to our office.

Patient Name: _____

Birth Date: _____

SSN: _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file.

I hereby authorized the release of all necessary medical records to Dr. Pauline Miller.

Patient Name: _____ Date:_____

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Signature of Witness: _____

Please forward records by mail or fax to:

Pauline Miller, MD
Advanced Internal Medicine
3416 North Buffalo Drive
Las Vegas, Nevada 8929

Ph. 702-982-8700
Fax. 702-982-8282