Red Rock Fertility Center
9120 West Russell Road, Suite 200
Las Vegas, NV 89148
Ph: 702-262-0079
Fax: 702-685-6910

Authorization for Release of Protected Health Information

I am scheduled at Red Rock Fertility Center on _____, and the office has requested that medical records be forwarded to the office prior to my scheduled appointment.

I hereby authorize:

Provider/Facility Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

To release a copy of the following information for patient: _____ (DOB: _____):
(please print name)

( ) All Records ( ) History and Physical

( ) Chart Notes ( ) X-Ray/Ultrasound

( ) Lab Results ( ) Operative Reports

Medical records may include confidential information related to communicable disease, alcohol or drug abuse, genetic information, blood, breath, or urine screen, and mental health diagnosis and treatment.

I ( ) DO ( ) DO NOT authorize the release of this type of information.

Patient Signature: _____ Date: _____

Note: This release will expire 6 months after the signed date.