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, _____, authorize Red Rock Fertility Center to release my medical records to:

Provider/Facility Name: _____

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

Phone: _____ Fax: _____

Patient Name: _____ DOB: _____

Date of Doctor's Appointment (if applicable): _____

Reason for Release: _____

Please release the following records:

( ) All Records	( ) History and Physical
( ) Chart Notes	( ) X-Ray/Ultrasound
( ) Lab Results	( ) Operative Reports

Patient Signature: _____ Date: _____

Please note, it will take 5-10 business days to process records requests.
If you are requesting records for personal use, there is a charge of $0.60 per page plus postage.
Note: This release will expire 6 months after the signed date.