MEDICAL RECORDS RELEASE

Date: __________

I hereby request that my medical records be released:

To: ________________________ From: ________________________

________________________ ________________________

________________________ ________________________

Please Release the Following:

Office Notes ______ X-Rays ______ EKG ______ Labs ________

Operative Reports _______ Hospital Records ______

Diagnostic Testing _______ **All Medical Records ______**

Patient's Name ____

DOB _______________________ Social Security # __________________

Patient's Signature ___________________________

700 Shadow Lane, Suite 166 Las Vegas, NV 89106
702-258-1601 * 702-870-1995 fax
www.CCCdoc.com

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