Authorization For Release Of Information

Patient: Name_____ Date of Birth _____
Address_____ Social Security # _____
City_____ State _____ Zip_____ Phone (___)_____

Clinic: Information Released From

Provider/Clinic Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Recipient: Information Released To

____Dr Wm Pierce, MD
YourMD
2451 W Horizon Ridge Pkwy Ste 110 **PH: 702-648-9998**
Henderson, NV 89052 **F: 702-648-9991**

Information To Be Disclosed: Medical Records Request

Date of Service _____

___Progress/Clinic Notes
___Special Tests; _____
___Consultation/Follow-up Reports
___Immunizations
___Imaging & Diagnostic Testing
___Lab Reports
___Hospital Reports
___Mental Health Notes
___Other _____
_____
_____
___All Of The Above

- **Please note, information in your chart that was not originally generated by YourMD or SFC will not be released to another facility. Such information must be obtained from the original source.**

Reason For Release _____

Expiration This authorization will expire on_____

Revocation I understand that I may revoke this consent at any time. I do not authorize further release to any third party. I understand that once information is released under this authorization, the clinic, their employees, and my physician cannot prevent the re-disclosure of that information.

Authorization I authorize the above provider to release the information marked above to the recipient

Signature of Patient/Guardian _____
Relationship to Patient (if Guardian) _____
Date of Signature _____

Medical Record Copies To Be ___ Mailed ___ Faxed ___ Picked Up