



## Authorization to Release Medical Records

Complete the form below and submit to your healthcare provider.  
This form should be downloaded and printed.

### PATIENT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Phone: \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### HEALTHCARE PROVIDER INFORMATION

The above patient is (or has been a patient of the following healthcare facility or provider:

Provider / Facility Name: \_\_\_\_\_  
Provider / Facility Phone Number: \_\_\_\_\_  
Provider / Facility Address (Street, City, ST, Zip): \_\_\_\_\_

The above patient authorizes the above healthcare facility/provider to release all medical records and to discuss health information with the following healthcare facility/provider:

**KLARITY CLINIC OF LAS VEGAS**  
Dr. Henry Liang  
5145 S. Durango Dr., #103  
Las Vegas, NV 89113  
844.552.7489 / FAX 888.945.4264

I understand that release of medical records may include patient histories, office notes, and working diagnoses. It may include drug, alcohol or substance abuse records, mental health records, procedural and surgical records, test results, current and past medications and treatments. Authorization is valid for 90 days from the date of signature unless revoked in writing. I have read and understand this consent and I have signed it voluntarily.

Patient Signature: \_\_\_\_\_  
Patient Name (printed): \_\_\_\_\_  
Date Signed: \_\_\_\_\_