RELEASE OF RECORDS

I hereby authorize: Desert Perinatal Associates
5761 S. Fort Apache Road
Las Vegas, Nevada 89148

To release my medical records to:

_____

_____

_____

Information contained in the medical records of:

Patient's Name: _____

Date of Birth: ____/____/____ SS#: _____

I understand that I may revoke the authorization at any time except to the extent that action has been taken in reliance on it and that in any event this authorization automatically expires 90 days from the date of my signature or as otherwise specified by date, event or condition as follows.

_____ _____
Patient's Signature Date

Comments: _____

_____