Brighton Family Medicine

Date: _____/_____/_____

Re: Request of Medical Information

Patient Name: _____

DOB: _____ Social Security # _____

I hereby request that you release:

_____

_____

_____

To:

Brighton Family Medicine
S. Steven. Kim M.D.
1720 W Horizon Ridge Pkwy Ste 140
Henderson NV 89012
T: (702) 566-5445 F: (702) 566-5035

X_____Date: _____
Patient/Legal Guardian Signature