GREEN VALLEY OB/GYN
100 N. Green Valley Parkway, #345
Henderson, NV 89074
(702) 260-0600 Fax: (702) 260-4444

MEDICAL RECORDS RELEASE FORM

Records to be Sent to: Name______________________________

_____ Pick Up Address______________________________

_____ Mail City/State/Zip______________________________

_____ Fax Phone and Fax______________________________

Patient Name______________________________ Date of Birth______________________

Social Security # ____________________________ Previous Name/Names____________________________

Address______________________________ City________________________ State_______

Zip Code _______________ Home Phone ____________________ Cell/Work Phone_____________________

Requesting Records:

_____ All Records _____ All Lab Results _____ Progress Notes

_____ Operative Reports _____ Other: ______________________________

Reason for Release:

_____ Transfer Care _____ Moving

_____ Own Records _____ Unhappy with Physician

_____ Unhappy with Staff _____ Second Opinion

_____ Other (Please Explain) ______________________________

I authorize **Green Valley OB/GYN** to release medical information to the above requester. I understand that per **Nevada State Law NRS 629 061**, I will be **charged .60 cents per page** for photocopies of my medical records. If I choose to have records mailed, I understand that the cost of postage is an additional charge. I also understand that per Nevada State Law, **the physician has up to 30 days to send records**.

Patient Signature______________________________ Date__________________________
(For Office Use)
Records Sent Date __________________________________ Employee Initials _________________________