Phone: (702) 837-1265 Fax: (702) 837-1706

12300 Las Vegas Blvd. South
Henderson, NV 89044

5757 Wayne Newton Blvd.
Las Vegas, NV 89111

Kochy M.Y. Tang, D.O.
Diane M. Levin, D.O.
Lorraine Vaughn, APN

Brian Bishop, APN

Authorization for release of information

I hereby authorize: ____
(Physician's name or Group)

Phone: ____________________ Fax: __________________________

To release all medical records to:

Kochy MY Tang, DO PC dba
M Family Care
12300 Las Vegas Blvd. South
Henderson, NV 89044

___Or other physician/facility: ____

Phone: ____________________ Fax: _______________________

Patient Name: ____

Social Security #______________________________ DOB ____________________

Information to release:

_____Entire record _____Clinical notes
_____Lab/Xray _____Other__________________

Note to the Recipient of Information: The information bas been disclosed to you from records whose confidentiality is protected by Federal Law. Unless the records of your program are also subject to the Federal Law, Federal Regulations prohibit you from making and further disclosure of the information without specific written authorization of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.

Signature of Patient: _________________________________Date: ________________