Orthopedic & Sports Medicine Institute of Las Vegas
Randa Bascharon D.O., Inc.
7281 W Sahara Ave. # 110 Las Vegas, NV 89117
Phone: (702) 947-7790 Fax: (702) 947-7792

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORDS

PATIENT NAME: _____ DOB: _____

I hereby authorize the physicians or employees of Orthopedic & Sports Medicine Institute of Las Vegas to : ☐ SEND ☐ REQUEST TO RECEIVE - my medical records

DURATION: Authorization shall become effective immediately and remain in effect for one year.

REVOCATION: Written revocation will be effective upon receipt.

SPECIFY RECORDS: Check the box for the type of information that is to be disclosed.

☐ ALL MEDICAL RECORDS ☐ HOSPITAL / REPORTS

☐ INS / PT INFO ☐ DOCTOR'S NOTES

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☐ PLEASE REQUEST MY MEDICAL RECORDS FROM:

ATTN: DOCTOR / CLINIC _____ PH: _____ FAX _____

ADDRESS _____ CITY _____ / STATE _____ / ZIP _____

PLEASE FORWARD ALL OF MY MEDICAL RECORDS TO:
ORTHOPEDIC & SPORTS MEDICINE INSTITUTE OF LAS VEGAS
7281 W. SAHARA AVE SUITE 110
LAS VEGAS, NV 89117 PH: (702) 947-7790 FAX: (702) 947-7792

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ATTN: DR. BASCHARON'S OFFICE:

☐ PLEASE SEND MY MEDICAL RECORDS TO :

DOCTOR OR CLINIC _____ PH: _____ FAX _____

ADDRESS _____ CITY _____ / STATE _____ / ZIP _____

_____
SIGNATURE OF PATIENT OR GUARDIAN DATE

IF SIGNED BY GUARDIAN, PLEASE PRINT NAME _____

RELATIONSHIP TO PATIENT: _____