



**Orthopedic and Sports Medicine Institute
of Las Vegas
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AUTHORIZATION FOR RELEASE OR DISCLOSURE OF MEDICAL RECORDS

I hereby authorize the physicians or employees of Orthopedic & Sports Medicine Institute of Las Vegas to forward / receive medical records.

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

REVOCACTION: Written revocation will be effective upon receipt.

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

ALL MEDICAL RECORDS

HOSPITAL/ REPORTS

INS/ PT INFO

DOCTOR'S NOTES

RELEASE MEDICAL RECORDS FROM / TO:

DOCTOR OR CLINIC _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE & FAX _____

PLEASE FORWARD ALL MEDICAL RECORDS TO:

ORTHOPEDIC & SPORTS MEDICINE INSTITUTE OF LAS VEGAS
7281 W. Sahara Ave. Suite 110
LAS VEGAS, NV 89117

PHONE: (702) 947-7790

FAX: (702) 947-7792

PATIENT NAME _____ **D.O.B.** _____

SIGNATURE _____ **DATE** _____