



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

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

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: _____