ROSEMAN MEDICAL GROUP
ROSEMAN UNIVERSITY OF HEALTH SCIENCES

Patient Name: _____ D.O.B.: _____

I authorize _____to release the following information from my medical records

To: _____
Name of: Person / Facility /Company Address

Phone: _____ Fax: _____

____History and Physical, Consult Reports
____Discharge Summary
____Medication Sheet
____Radiology Reports
____Echocardiogram Reports
____Holter Monitoring Reports
____Coronary Catherization Reports
____Angiogram Reports
____Stress Test Reports
____EKG Reports

____Laboratory Test Results
____Microbiology Reports
____Pathology Reports
____Colonoscopy Report
____Mammogram Report
____Pulmonary Function Test Result
____Arterial Blood Gases
____Bronchoscope Report
____Other
____Other

Or
____ALL Medical records

The requested information may be delivered by mail, facsimile or any other means authorized by me or permitted by law. I understand that I may revoke this consent at any time before the information has been released. This authorization expires one (1) year from the date below.

Any alcohol or substance use information, HIV or AIDS- related information released is protected by Federal Regulations and may not be re-disclosed without an explicit written consent of the undersigned

Patient /Legal Guardian Signature: _____ Date:_____

Signature of Legal Representative: _____
(Copy of POA for Health Care must be attached)

Print Name of Legal Guardian/Representative: _____

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5380 S. Rainbow Blvd., Suite 120, Las Vegas, NV 89118
Phone: 702-463-4040 Fax: 702-968-5681