ROSEMAN MEDICAL GROUP
ROSEMAN UNIVERSITY OF HEALTH SCIENCES

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

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
____EKG Reports
____Laboratory Test Results
____Microbiology Reports
____Pathology Reports
____Colonoscopy Report
____Other

Or
____ALL Medical Records

Sensitive Information: Medical records may contain information concerning alcohol or substance use, sexually transmitted infections (STI), HIV testing and/or AIDS diagnosis and treatment, as well as mental health records. (initial applicable lines below to authorize release):

_____ Alcohol or substance use

_____ STI records

_____ HIV/ AIDS related records

_____ Mental Health records (excludes "psychotherapy notes")

Any sensitive information released is protected by Federal Regulations and may not be re-disclosed without explicit written consent of the undersigned.

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.

Patient /Legal Guardian Signature: _____ Date: _____

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

Print Name of Legal Guardian/Representative: _____