

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
Name of Physician, Hospital or Facility

Address: _____
Address City State Zip Code

Phone: _____ Fax: _____

From: _____
Name of Patient

Re: Request for Release of Medical Records

I hereby request that my medical records, without limitations, including any HIV test results and/or treatment and any psychiatric records, be released to:

**Jateko Family Medical Group
6850 North Durango Drive, Suite 400
Las Vegas, NV 89149**

This authorization releases my medical records for the following designated purpose:

This release is valid for 30 days after this date.

I understand that I am entitled to receive a copy of this release.

Signature of Patient or Legal Guardian

Patient's Date of Birth

Print Patient's Name

Date Signed

Print Name of Legal Guardian (relationship), if applicable

Witness