Forte Family Practice Medical Record Request Form

Patient Information:

Patient Name:_____Date of Birth:_____/_____/_____

Address:_____Social Security #:_____

City:_____State:_____Zip Code:_____Phone: (_____)_____-_____

Obtain Records From:

Provider/Clinic Name:_____

Address:_____City:_____State:_____

Phone: (_____)_____-_____ Fax: (_____)_____-_____

Send Records To (circle one):

9010 West Cheyenne Ave
Las Vegas, Nevada 89129
Phone (702) 240-8646
Fax (702) 240-0206

4845 South Rainbow Blvd
Las Vegas, Nevada 89103
Phone (702) 362-9800
Fax (702) 871-9805

Information To Be Sent:

_____ All Records _____ Other:_____

Reason for Release:

Expiration: This authorization will expire on _____/_____/_____

Revocation: I understand that I may revoke this consent at any time. I do not authorize further release to any third party. I understand that once information is released under this authorization, the clinic, the employees, and my physician cannot prevent the disclosure of that information.

Authorization: I authorization for the above provider to release the information marked above to the recipient.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative | Relationship to Patient