Sanford F. White, MD, MPH
5771 S. Fort Apache Rd. Suite 100 Las Vegas, NV 89148
Phone: (702) 951-3400 Fax: (702) 951-3403

AUTHORIZATION

FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This form is used to request a copy of health information in your possession for the following patient(s):

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

I authorize information released from:

_____
PHYSICIAN NAME

_____
PHYSICIAN STREET ADDRESS

_____
CITY STATE ZIP

PHONE : ( ) _____

FAX: ( ) _____

Please send my records to:

Ensign Family Medicine
Sanford F. White, MD, MPH
5771 S. Fort Apache Rd. Suite 100
Las Vegas, NV 89148
Phone: (702) 951-3400
Fax: (702) 951-3403

Information requested:
The undersigned authorizes the above named Physician or office to release the following information:

_____ All Records _____ Immunization Records _____ Progress Notes

_____ Consultations _____ Labs _____ X-ray Reports

_____ Hospital Records _____ Other :_____

I acknowledge that I have the right to revoke this authorization at any time by submitting a written revocation. I understand that once the information is disclosed, it may no longer be protected by federal privacy law.

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____ Self _____ Parent _____ Other_____

Date Faxed: _____