AUTHORIZATION TO RELEASE MEDICAL RECORDS
GYNECARE

(MARIA KELLER M.D.)
8605 S. EASTERN AVE. STE C2
LAS VEGAS, NV 89123

PLEASE PRINT CLEARLY

Patient Name: _____
Social Security Number: _____ DOB: _____

I authorize Dr. Maria Keller to receive confidential medical information regarding the following:

❑ Gynecologic Records ❑ Entire Medical Record
❑ Laboratory results from (date): _____ Name of Lab test(s): _____
❑ X-ray and/or Diagnostic Report from (date): _____ Type X-ray: _____
❑ Other: _____

PREVIOUS DOCTOR AND/OR NAME OF MEDICAL FACILITY: _____
PHONE: (_____)_____ FAX: (_____)_____
SIGNATURE: _____ DATE: _____

PLEASE FAX REQUESTED INFORMATION BACK TO (702) 252-3000

If you are requesting your records to be released to another individual or organization outside of our office, please give the following information:

Name of individual to release your information to: _____

		( )	( )
Address	City, State, Zip	Phone number	Fax number

REASON FOR REQUEST: (PLEASE CHECK ONE)

❑ Transferring Care to another Doctor ❑ Insurance ❑ Personal/Self ❑ Attorney

Signature of Patient/Guardian: _____ Date: _____

THERE IS A CHARGE OF $0.60 PER PAGE WHEN RELEASING RECORDS DIRECTLY TO THE PATIENT. PLEASE ALLOW UP TO 10 BUSINESS DAYS FOR PROCESSING.