

NEVADA WOMEN'S CARE
ROBERT A. GATLIN M.D. | ELENA LANGDON M.D.
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Authorization to obtain or release medical records

Date: ___ / ___ / ___ Patient name: _____
Date of birth: ___ / ___ / ___ Social security number: _____ - _____ - _____

Hereby authorize Robert A. Gatlin M.D.

To: Obtain Release From To

YOU MUST PROVIDE A COMPLETE MAILING ADDRESS

Address: _____

RELEASE FOR REQUEST: (PLEASE CHECK ONE)

Medical care Insurance Personal Attorney

Copies of medical records to include: _____

And date from: _____ to: _____

Patient signature: _____ Witness signature: _____

I give permission to release any information regarding (initial on applicable lines below):

_____ substance abuse, _____ psychiatric/mental health info, _____ HIV info.

This information has been disclosed to you for records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

THERE MAY BE A CHARGE OF 60 CENTS PER PAGE PLUS POSTAGE. AUTHORIZATION EXPIRES AFTER 6 MONTHS. PLEASE ALLOW 10 BUSINESS DAYS FOR PROCESSING. PLEASE CALL (702) 737-3200 (M-F)
