Nevada Women's Care
Keeping women well with convenient, gentle care

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Authorization to obtain or release medical records

Patient to complete

Patient name: _____ Date of birth: _____

Address: _____ SSN: _____

City, State, ZIP: _____ Phone: _____

Patient signature: _____ Date: _____

Office to complete

Hereby authorize Robert A. Gatlin, MD

To: ☐ obtain ☐ from or ☐ release ☐ to

Centennial Hills Hosp 629-1300 Fax: 629-1645	Desert Radiology-GV 387-6900 Fax: 990-5342	Desert Springs Hosp 369-7704 Fax: 369-7556	Mountain View Hosp 255-5048 Fax: 255-5007	North Vista Hosp 657-5533 Fax: 649-1523
Spring Valley Hosp 853-3531 Fax: 853-3144	Southern Hills Hosp 880-2130 Fax: 880-2131	Steinberg Diagnostics 732-6000 Fax: 731-3879	St. Rose: de Lima 616-4642 Fax: 616-4644	St. Rose: San Martin 492-8642 Fax: 492-8165
St. Rose: Siena 616-5642 Fax: 616-5235	Summerlin Hosp 233-7581 Fax: 233-7916	Sunrise Hosp 731-8663 Fax: 892-3686	UMC Hosp 383-2228 Fax: 383-2012	Valley Hosp 388-4580 Fax: 388-4752

Office name: _____ Office name: _____

Address: _____ Address: _____

City, State, ZIP _____ City, State, ZIP _____

Main phone: _____ Main phone: _____

Main fax: _____ Main fax: _____

I hereby authorize any or all of the above named parties to release to Nevada Women's Care my protected health information, including diagnosis records of treatment, consultation or examination, diagnostic laboratory testing results, radiology reports, ancillary testing reports, including mental health/substance abuse HIV/AIDS related treatment rendered to me. I understand that Nevada Women's Care may not be the ordering or referring physician for the above protected health information but as my primary obstetrician and gynecologist, I request that a copy be disclosed to them. I also understand that this release expires after 12 months and is revocable by me at any time.

Please send the following records as soon as possible:

	History & physical		Lab reports		Other		
	Pathology report		X-ray of	Xxx	Delivery summary		Operation report
	Discharge summary		U/S of	xxx	MRI of		Consultation report
					C/T of		All records