Medical Records Release

Patient Name _____ DOB_____

Social Security Number _____

For purposes in continuity of care, I authorize release of my medical records:

To:

DECON (Diabetes & Endocrine Center of Nevada)
3983 S. McCarran Blvd #571
Reno NV 89502-7510
775.507.2555 Phone
775.284.9082 Fax

From:
Physician/Facility: _____
City, State, Zip: _____
Phone: _____

Records to be released: _____Entire File ____Lab _____X-ray _____Operative Reports
_____Consultations _____Other (list) _____

I authorize release of my medical records to/from the above listed, even if these records contain information concerning:

- Psychiatric/psychological testing, diagnosis, history, and/or treatment
- Alcohol or drug testing, diagnosis, history, and/or treatment
- STD and HIV testing, diagnosis, history, and/or treatment
- Sickle cell anemia testing, diagnosis history, and/or treatment

I understand there may be a charge for the copying of the records.

I authorize release of my records by fax/mail. This authorization applies to all medical records created prior to the date of my signature below and expires immediately after these records are released. I understand, I may revoke this at any time until the records are released.

**Signature _____ Date _____

Witness _____