

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND  
INFORMATION**

**TO:** (name of hospital/facility/clinic/doctor) \_\_\_\_\_

**FAX NUMBER:** \_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_ hereby authorize the above mentioned medical facility/physician noted below to release any and all of my medical records, reports, lab reports to:

**Farrukh Imtiaz, M.D.  
Nevada Medical Clinic  
4445 S. EASTERN AVENUE, SUITE B  
LAS VEGAS, NEVADA 89119  
TEL: (702) 933-6767  
FAX: (702) 933-6770**

**Patient Name:** \_\_\_\_\_

**SSN:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**PHONE#:** \_\_\_\_\_

**HOME ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patients'/legal representative signature:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**KINDLY EXPEDITE AND FAX RECORDS ASAP!!!! THANKS IN ADVANCE FOR YOUR ANTICIPATED CO-OPERATION IN THIS MATTER.**