MEDICAL RECORDS RELEASE FORM

DATE: _____ **STAT REQUEST ( )**

Patient Name: _____

Patient Address: _____

DOB: _____ SSN: _____

Please release all pertinent medical records, imaging studies, and laboratory test results to:

Las Vegas Pediatric Urology
653 N. Town Center Dr., Suite 407
Las Vegas, NV 89144
Tel: 702-728-5686 Fax: 702-628-9030

_____ _____
Signature of Patient or Authorized Patient Representative Date

_____
Relationship to Patient
(Mother, Father, Legal Guardian, Foster parent, court-appointed case worker, etc.)