

**DESERET WOMEN'S HEALTH CARE
RELEASE OF MEDICAL INFORMATION**

I authorize the release of medical information:

____ ALL MEDICAL RECORDS ____ OTHER _____

I authorize the above records to be released from:

DWHC – Fax (702) 564-8058 OR

Facility/Provider - Name, Address, Phone, and Fax information:

I authorize the above records to be released to:

DWHC – FAX (702) 564-8058 OR

Facility/Provider/Myself- Name, Address, Phone, and Fax Information:

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PATIENT'S SOCIAL SECURITY #: _____

PHONE #: _____ ALT. PHONE#: _____

I authorize Deseret Women's Health Care to Release Medical Information to the above – from and to of I, the requester. I understand that per Nevada State Law NRS 829.061 I will be charged \$0.60 per page to cover the costs of sending my medical records.

PATIENT SIGNATURE: _____ DATE: _____

FOR OFFICE USE

RECORDS/RELEASE SENT DATE/ HOW: _____ EMPLOYEE INITIALS: _____

DESERET WOMEN'S HEALTH CARE 98 E. LAKE MEAD PKWY., STE. 105, HENDERSON, NV 89015
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