CENTER FOR HEALTH INTERNAL MEDICINE ASSOCIATES
Shaheen Ali, M.D.
Jennifer M. Leary, APN * Cassie Wellock, PA-C * Ashley McCoy,
APRN 645 N. Arlington Ave., Suite 600
Reno, NV 89503
P: 775.322.3393 F: 775.322.3385

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient's Name_____ Birthdate_____
First MI Last

Are medical records under another name?_____

I hereby authorize the below to release medical records: (circle one)

Center For Health Internal Medicine Associates or

Other:_____
Name Address Phone

Please release my records to:

Center For Health Internal Medicine Associates or

Other:_____
Name Address Phone

Email records to:_____ or Fax records to:_____

Please send the following specific information concerning my health in your facility:

_____ All records to include sensitive information such as HIV, substance abuse, etc.

_____ All records within the last 3 years.

_____ Radiology reports

_____ Lab studies

_____ Other: (indicate specific illness, procedure, date(s) of treatment, etc._____

Reason for request:

_____ Continuity of Care _____ Second Evaluation _____ Other:_____

I understand that I may revoke this consent at any time and that this consent will automatically expire 90 days from the date signed below. This hereby release sthe sender from all legal responsibility or liability which may result from the release of my medical records.

Signature_____ Date_____
Patient or authorized representative

Witness_____ Date_____