MEDICAL RECORDS REQUEST AND AUTHORIZATION FOR TRANSFER

Patient Name: ________________________________ Date of Birth:__________________

I hereby authorize ____

Address: ____

City: ______________________________Phone: ________________Fax:_________________

To release copies of my medical records and request that they be sent to:

Thomas E Killeen, MD: _______________

David L. Mathis, MD: _______________

Joshua Meier, MD: __________________

Keely Chevallier, MD: _______________

Address: 9770 S McCarran Boulevard, Reno, NV 89523

Telephone: (775) 322-4589 Fax: (855) 839-6120

____ All Records Other:

____

I, the undersigned, have read and filled out the above information and authorize the release of my records to Nevada ENT & Hearing Associates.

____ __________________________

Signature of Patient or Person Authorized to Consent **Date**