INTEGRATIVE WOMEN'S HEALTHCARE OF NEVADA
ROBI BURNS, M.D

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____

SSN: _____ **DOB:** _____

TO / FROM : **INTEGRATIVE WOMANS HEALTHCARE** **DR. ROBI BURNS M.D** **2633 HORIZON RIDGE PARKWAY** **HENDERSON, NV 89025** **PHONE: 702 853-1400 FAX: 702 456-0856**	**TO / FROM**: **FACILITY NAME**:_____ **ADDRESS**:_____ _____ **ATTN**:_____ **PHONE**:_____**FAX**:_____

I hereby authorize the staff, physicians and/ or agents in behalf of **ROBI BURNS, M.D.**
To: Receive / Request confidential medical information regarding the following:

__Obstetrical Records
__Gynecologic Records
__Entire Record
__Laboratory results from (date) _____ Name of lab test (s): _____

___X-ray and Diagnostic Report from (date) _____ Type of X-ray_____

___Other: _____

_____

REASON FOR REQUEST: (PLEASE CHECK ONE)

____ Transferring care to another doctor ____ INSURANCE ____ PERSONAL _____ ATTORNEY

Please Print : **Patient Last Name** : _____ **First Name**: _____

Signature of Patient/ Guardian: _____ **Date**: _____

****There will be a charge of $0.60 per page when releasing records directly to the patient. Please allow ten 10 business days for processing.**