NG FAMILY HEALTHCARE
CONCIERGE MEDICINE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Printed Patient Name:	**Date of Birth:**
Last 4 of SSN:	**Phone:**

Previous Doctor/Organization to Release Information:	
Address	
Phone Number	**Fax Number**

By signing this form, I authorize you to release confidential health information about me. By releasing a copy of my medical records, or a summary or narrative of my protected health information, to the facility below.

Ng Family Healthcare
8285 W. Arby Ave Ste 390
Phone Number: 702-847-7744 **Fax Number: 702-847-7745**

The information you may release subject to this signed release form is as follows:

- ☐ Complete Record for the last two years
- ☐ Office notes (except psychotherapy notes)
- ☐ Test / imaging results / pathology
- ☐ Other: _____
- ☐ Records sent by other health care provider
- ☐ Hosp / operative reports / care plans
- ☐ Consults

The purpose / reason for this release of information is as follows:

- ☐ Continuity of Care
- ☐ Other: _____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization. I have the right to revoke this authorization in writing at any time.

_____ _____ _____

Patient Signature Patient Printed Name Date