Medical Genetics of Nevada LLC

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Protected Health Information (PHI)-Transfer of Records-Patient Request

Patient Name: _____ Patient DOB: _____

Social Security Number: _____

Address:_____City:_____

State: _____ Zip Code:_____

I authorize the use or disclosure of the above-named individual's PHI to be released as follows:

All Medical Records ***Genetic Testing Results Only*** ***Physician Reports Only (includes family history)***

Reason for Request (circle one):

Medical Care ***Personal*** ***Insurance*** ***Attorney*** ***Other***

Transfer Records From:

Name:_____

Address:_____ City:_____

State:_____ Zip Code:_____

Phone:_____

Fax: _____

Send Records to:

Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Phone: _____

Fax: _____

Signature of Patient, Parent, Guardian or Personal Representative
(If guardian or representative, attach supporting documentation and ID)

Signature:_____ Date:_____

Print Name:_____

Relationship to Patient:_____

Within the limitations of the law, we will make every effort to accommodate your request and I understand that Medical Genetics of Nevada has 30 days to respond, however our goal is 3 to 5 days. Please contact the Medical Records Department if you have any questions.