

# Haydee Docasar, M.D.

www.haydeedocasarmd.com

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

I hereby authorize the staff, physicians and/ or agents in behalf of  
**HAYDEE DOCASAR, M.D.**  
To receive 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: \_\_\_\_\_

### RELEASE TO / FROM

Previous Doctor and/ or name of Medical Facility: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PLEASE FAX REQUESTED RECORDS TO: 1-855-898-8685

If you are requesting your records to be released to another individual or organization outside of our office please give the following information:

### RELEASE TO INDIVIDUAL

Name of individual to release your information to : \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

### REASON FOR REQUEST: ( PLEASE CHECK ONE )

Transferring care to another doctor  INSURANCE  PERSONAL  ATTORNEY

Signature of Patient/ Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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

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