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## RELEASE OF RECORDS

I hereby authorize: Desert Perinatal Associates  
5761 S. Ft. Apache  
Las Vegas, Nevada 89148

To release my medical records to:

\_\_\_\_\_  
Name of company/provider/person

\_\_\_\_\_  
PHONE NUMBER & FAX NUMBER

\_\_\_\_\_  
EMAIL/MAILING ADDRESS (if applicable)

Information contained in the medical records of:

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security #: \_\_\_\_\_

I understand that I may revoke the authorization at any time except to the extent that action has been taken in reliance on it and that in any event this authorization automatically expires 90 days from the date of my signature or as otherwise specified by date, event or condition as follows.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

Comments: \_\_\_\_\_

Southwest Location: 5761 S. Ft. Apache • Las Vegas, Nevada 89148  
Summerlin Location: 10105 Banburry Cross, #430 • Las Vegas, Nevada 89144  
Green Valley Location: 3001 Horizon Ridge Parkway • Henderson, Nevada 89052  
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