Sahara Medical Institute- 5781 W. Sahara Avenue. Suite 500. Las Vegas, NV 89146

RECORD TRANSFER REQUEST

DATE: ______________________________

PATEINT(S) NAME:

____

____

PATIENT DOB(S):

____

____

PATIENT'S DOCTOR:

____

PLEASE RELEASE RECORDS TO:

____

ADDRESS:

____

PLEASE CONTACT ME AT___________________________IF ANY QUESTIONS

REGARDING THE RELEASE OF MY (CHILD OR CHILDRENS RECORDS)

Thank You.

SIGNATURE,

(PATIENT, PARENT OR GUARDIAN)____