AUTHORIZATION TO RELEASE MEDICAL RECORDS
GYNECARE

(MARIA KELLER M.D.)
8606 S. EASTERN AVE. STE C2
LAS VEGAS, NV 89123

PLEASE PRINT CLEARLY

Patient Name: _____

Social Security Number: _____ DOB: _____

I authorize Dr. Maria Keller to receive confidential medical information regarding the following:

❑ Gynecologic Records ❑ Entire Medical Record

❑ Laboratory results from (date): _____ Name of Lab test(s): _____

❑ X-ray and/or Diagnostic Report from (date): _____ Type X-ray: _____

❑ Other: _____

PREVIOUS DOCTOR AND/OR NAME OF MEDICAL FACILITY: _____

PHONE: (_____)_____ FAX: (_____)_____

SIGNATURE: _____ DATE: _____

PLEASE FAX REQUESTED INFORMATION BACK TO (702) 252-3000

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