CONCIERGE CARPAL TUNNEL and HAND SURGERY

I ____, HEREBY REQUEST THAT COPIES OF MY MEDICAL RECORDS AND TESTS BE RELEASED TO:

Concierge Carpal Tunnel and Hand Surgery

Ryan J. Grabow, MD
3175 St. Rose Pkwy #330
Henderson, Nv 89052
Phone: 702-433-9533
Fax: 702-478-5492

I authorize Concierge Carpal Tunnel and Hand Surgery: Dr. Ryan J. Grabow and or their agents to obtain my medical records from other physicians or parties. A photocopy of this form may be used in lieu of the original.

Please Include all the Following to be released:

( )The Entire Medical Record

( ) All Radiology Tests: ( ) X-rays, ( ) Cat Scans, ( ) MRI, ( ) Other: ________________________________

( ) Specific Dates Of Service: ___/___/_____ to ___/___/_____.

Patients Name: ____

Date of Birth: ____/____/________ Social Security #:_________________________________

Affirmation of Release:
By signing below, I give my permission to release my medical records and studies to Concierge Carpal Tunnel and Hand Surgery. I understand that this release is valid for up to one year from the date of signature and I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. Any revocation or refusal to sign this authorization will not prevent medical treatment or payment. I understand that a revocation must be sent in writing.

____ ________________________

Signature of Patient/Guardian/Legal Representative Date

*HIPPA Regulations require that the following statement be present on this release: The information disclosed may be subject to redisclosure by recipient and no longer protected. This authorization may be revoked at any time.