



*Nevada Fertility C.A.R.E.S.*

*Center for Advanced Reproductive Endocrinology and Surgery*

Date: \_\_\_\_\_ Total # of pages (including fax sheet): \_\_\_\_\_

To: \_\_\_\_\_ Recipient Fax: \_\_\_\_\_

From: \_\_\_\_\_ Sender Fax: \_\_\_\_\_

## **Request for Release of Medical Records**

I hereby request that my complete medical records, laboratory data, x-rays, and other related materials be released to:

*Nevada Fertility C.A.R.E.S.*

Rachel A. McConnell, M.D. & Eva Littman, M.D.

653 Town Center Drive, Suite 206

Las Vegas, NV 89144

**Patient's Name** \_\_\_\_\_

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

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

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

Summerlin Medical Center  
653 Town Center Drive, Suite 206, Las Vegas, Nevada 89144  
702 341-6616 Fax 702 341-6617

*Board Certified in Reproductive Endocrinology & Infertility*