Date: ______________________________

I hereby request the release of my medical records or copies of such and request that they be transferred/released from:

Doctor/Office: ______________________________

Address: ______________________________

City: __________________ *State* __________ *Zip* __________

To:

Doctor/Office: ______________________________

Address: ______________________________

City: __________________ *State* __________ *Zip* __________

______________________________ DOB __________
Print Name of Patient

____
Signature of Patient or Parent/Guardian

Robert J. Riley, M.D.
6630 S. McCarran Blvd. Unit A 9
Reno, Nevada 89509
ph 775-829-1212 fax 775-829-1179