P.O. BOX 35020 Las Vegas NV 89133-5260 Fax: 258-1672

Authorization to Disclose Protected Health Information (PHI)

This request to RELEASE medical records will be returned if not completed in its entirety

Patient Name: ______________________________ Medical Record Number: __________

Address: ______________________ City: ________ State: _____ Zip: ________ DOB __________

I AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUAL'S PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW:

① The type and amount of information to be used or disclosed is as follows

Include dates where appropriate: **FROM** (date) **THROUGH** (date)

☐ **Entire Record**, or: ☐ H&P ☐ OP Report ☐ Progress Notes ☐ Last two days/medical records

☐ D/C Summary ☐ Consult ☐ X-Ray Reports ☐ Labs ☐ Therapy Notes

☐ Other ______________________________

② Please initial for release of the following information even if you checked "Entire Record" above.

_______ **Substance Abuse** _______ **Psychiatric / Mental Health Information** _______ **HIV Information**

_______ **Genetic Test Results** _______ **Child & Domestic Abuse History** _______ **Addictive Behavior**

_______ **Communicable and Sexually Transmitted Disease**

③ REASON FOR REQUEST: (PLEASE CHECK ONE)

☐ Medical Care ☐ Insurance ☐ Personal ☐ Attorney ☐ Home Health Care Treatment ☐ Other __________

④ I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ______________________________ **IF LEFT BLANK, THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS**

⑤ THIS INFORMATION IS TO BE DISCLOSED TO ☐ Requestor ☐ the following individual or organization

Name ______________ Phone number ______________ Fax number ______________

Address ______________ City, State, Zip ______________

⑥ I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department and obtain a copy of the Privacy Notice.

⑦ I wish to receive this information on ☐ Paper ☐ Email *(as a PDF file)*

Signature of Patient: ______________________________

Date of Signature

Signature of Parent, Guardian
or Personal Representative
(if necessary): ______________________________

(If Personal Representative, attach supporting documentation)

Date of Signature

NOTE: There is a charge of 60 cents per page unless information is being disclosed to a medical facility.
PLEASE ALLOW 30 BUSINESS DAYS **from date of receipt by HIM Dept FOR PROCESSING.**
Phone: (702) 877-0814 M-F, 8am-5pm