Fax completed form attention Maria to (702)759-1412

Authorization to Disclose Patient Health Information

Patient/Client Name: _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Social Security # : (optional) _____ Phone #: _____

I authorize the disclosure of the above named individual's Protected Health Information (PHI) and request the **Southern Nevada Health District** to release the requested information to:

Name: _____

Address: _____

Release of Information may be *(Please initial*) _____Verbal _____Written _____Faxed

_____Mail _____ Call for pickup Phone #:_____ Fax # _____

The purpose for this requested information is: *(Note: There is a $0.60 per page photocopy fee)*

☐ Continuity of Care ☐ Personal use ☐ Consultation ☐ School Transfer ☐ Attorney ☐ Insurance

☐ Other, specify: _____

Date(s) of services requested:_____

I understand that It may take 5 business days and no more than 30 days for a disclosure request to be processed

The following information is requested:

☐ ***Entire Health Record**
☐ Pap Report
☐ Consent forms
☐ Images / xrays
☐ Immunization records
☐ Lab Test (specify type of test)_____
☐ GYN Physical Exam
☐ Progress Notes
☐ Psychotherapy Notes
☐ Other, specify:_____

I acknowledge and hereby understand that releasing my Entire Health Record may contain information relating to HIV or AIDS, treatment for alcohol and/or drug abuse, sexually transmitted disease, or medical testing content. _____(Initials).* *DO NOT RELEASE* ☐ HIV or AIDS, ☐ treatment for alcohol and/or drug abuse, ☐ sexually transmitted disease, or ☐ medical testing content _____*(Initials).*

This authorization will expire on the following date or event: _____ or 180 days from date of signature.

I understand that:

1. If I do not authorize the release of my full health record, the recipient will be notified that only a limited health record is provided per patient request.
2. Authorizing this release of information is voluntary and I may refuse to sign this authorization.
3. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization except where the treatment is for the purpose of research or solely for purpose of creating a health record for disclosure to a third party.
4. I may revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it.
5. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy regulations.

The Southern Nevada Health District, its employees and healthcare providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient or Patient's Legal Representative **Today's Date**

_____ _____
Print Name of Legal Representative (if applicable) **Relationship to Patient (if not the Patient)**

Note: *Guardians and Durable Power of Attorney designees should include a copy of the applicable paperwork*

Southern Nevada Health District – 625 Shadow Lane – Las Vegas, NV 89127 – Tele: 702-759-1204