Fax completed form to (702) 759-1412 Attn: Legal

Authorization to Disclose Patient Health Information

For Office Use Only:
Approved: _____
Date: _____

Southern Nevada Health District – PO Box 3902 – Las Vegas, NV 89127 – Tele: 702-759-1364

Patient/Client Name (please print): _____ Male/Female (circle one) Birthdate:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

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: *(Note: There is a $0.60 per page photocopy fee)*

Name(please print): _____

Address: _____

Release of Information may be *(indicate **one**)*: _____Mailed; Faxed to a **secure** Fax #_____;
_____Call for in-person pickup; Emailed encrypted to:_____

The purpose for this requested information is:

☐ Continuity of Care ☐ Personal use ☐ Consultation ☐ School Transfer ☐ Attorney ☐ Insurance
☐ Other, specify:_____

The following information is requested:

☐ Immunization records
☐ TB Clinic Records
☐ Lab Test (specify type of test)_____
☐ Refugee Clinic Records
☐ Food handler/Health Card Testing
☐ Sexual Health Clinic
☐ HIV Case Management
☐ Family Planning Records
☐ Outreach HIV/STD screening
☐ Healthy Kids Exam/Maternal Child Heath Records
☐ Other, specify:_____
☐ Specify dates of services, if known: _____

I acknowledge and hereby understand that releasing my health records may contain information relating to HIV or AIDS, treatment for alcohol and/or drug abuse, and/or sexually transmitted disease.
I consent to release: ☐ HIV or AIDS, ☐ treatment for alcohol and/or drug abuse, and/or ☐ sexually transmitted disease. _____ *(INITIALS).*

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

I understand that:

1. Authorizing this release of information is voluntary and I may refuse to sign this authorization.
2. 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.
3. I may revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it.
4. 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*