



Email completed form to legal@snhd.org or fax to (702) 759-1412

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:

- | | |
|--|--|
| <input type="checkbox"/> Immunization records | <input type="checkbox"/> Sexual Health Clinic |
| <input type="checkbox"/> TB Clinic Records | <input type="checkbox"/> HIV Case Management |
| <input type="checkbox"/> Lab Test (specify type of test) _____ | <input type="checkbox"/> Family Planning Records |
| <input type="checkbox"/> Refugee Clinic Records | <input type="checkbox"/> Outreach HIV/STD screening |
| <input type="checkbox"/> Food handler/Health Card Testing | <input type="checkbox"/> Healthy Kids Exam/Maternal Child Health Records |
| | <input type="checkbox"/> Other, specify: _____ |
| | <input type="checkbox"/> 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