



AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Date of Birth: _____ Patient's Name: _____
SS#: _____

I authorize Nevada Regional Medical Center
[] release to: [] obtain from:

Name of Person/Facility/Insurance Company

Complete Mailing Address

The requested information to be released shall consist of duplicated records concerning the treatment on or about:

The type of information to be used or disclosed consists of:

- [] Problem/diagnosis [] Allergies [] Lab results [] Discharge Summary
- [] X-ray and imaging reports [] Medication list [] Immunization records
- [] Consultation reports [] History and physical [] Psychiatric Evaluation
- [] Other (please describe) _____

The information is to be used for the purpose of :

- [] Follow-up care/further treatment [] Personal files [] Insurance determinations
- [] Legal [] Other _____

This authorization contains restrictions [] Yes [] No If yes, see Disclosure restriction form in Medical Record.

I have read and understand the nature of the authorization. I understand certain information in my health records may include sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), alcohol*, drug abuse* and mental health records. *Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2, and the HIPAA Privacy Rule, 45 CFR, Parts 160 and 164. Redisclosure shall not be permitted without specific written authorization of the person to whom it pertains. Redisclosure by the recipient may no longer be protected by the privacy rule.

This authorization may be revoked at any time by the patient. The revoking of this authorization shall not cancel any prior action that has already transpired. Specification of date, event, or condition upon which this consent expires is: (if left blank this consent expires 90 days after the last treatment date, unless this is an insurance request at which time it will expire after insurance benefits have been paid) _____.

Signature of Patient/Guardian/Legal Representative Date

Witness Date Witness Date
(verbal approval requires 2 witnesses)

NOTICE OF REVOCATION I hereby revoke my authorization to release the above specified information. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Patient TO _____
Person, Agency, Organization

This revocation effectively makes null and void any Release of Information expressly given by the above authorization.

Patient signature/Guardian/Legal Representative Date Witness Date