



FAMILY HEALTHCARE SERVICES

8655 S. Eastern Ave, Las Vegas, NV 89123 Fax: 560-2963
Authorization to Disclose Protected Health Information (PHI)

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

Patient Name: _____ SSN: _____ 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 CD (as a PDF file)

Signature of Patient: _____ Date of Signature

Signature of Parent, Guardian
 or Personal Representative
 (if necessary): _____ Date of Signature
(If Personal Representative, attach supporting documentation)

**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) 383-0887 M-F, 8am-5pm**