AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION AND WAIVER OF CONFIDENTIALITY

Patient Name: _____ DOB: _____ SS#:_____

I consent to the release of medical information from my patient records as described below. This information may be released by:

Clinician Name:

_____

To be sent to: Name: _____

Address: _____

Phone: _____ Fax: _____

I. FOR THE DISCLOSURE OF DRUG OR ALCOHOL ABUSE INFORMATION, (including any patient information which may identify the patient as having had, being under, or in need of treatment for drug abuse):

The disclosure of records that I authorize is required for the following purpose: _____

_____

and such disclosure shall be limited to the following specific types of information: _____

_____

_____

II. FOR ALL OTHER DISCLOSURES:

I authorize the release of the information indicated below to: _____

_____

PLEASE INITIAL THE INFORMATION AUTHORIZED FOR RELEASE

Psychiatric Assessment _____ Progress Notes _____ Medication Records _____ Psychiatric Diagnoses _____ Psychological Test Results _____ Consultation Reports _____ Financial Information _____

Summary Information _____ Entire Client File _____

Other (specify): _____

_____

III. EFFECTIVE DATE AND REVOCATION:

This consent is effective beginning on the date I sign it. It may be revoked at any time by delivering written notice to Administrator, University of Nevada School of Medicine, Department of _____, Las Vegas, NV 89_____ and the revocation will be effective as the date received, except to the extent the provider has taken action in reliance on this consent.

IV. PLEASE READ AND INITIAL THE FOLLOWING STATEMENTS:

_____ 1. I am aware that my records are confidential under state and federal law and, except in certain limited circumstances, those records may not be disclosed without my consent.

_____ 2. I understand that once my records are disclosed to a person or organization, the law may not protect me

against further disclosures by that person or organization.

_____ 3. I understand that the release of information about my health status, my psychiatric treatment or diagnosis and/or my diagnosis or treatment for drug or alcohol abuse could have adverse consequences for me.

_____ 4. I understand that the release of records authorized in this consent cannot be made unless I give this consent.

_____ 5. I understand that I have the right to refuse to give this consent; and that my clinician will not condition treatment on obtaining this consent.

_____ 6. In light of the above, and in full consideration of the possible effects of this consent, I have voluntarily signed this consent.

_____ 7. I understand and agree that the information to be disclosed includes the following types of information which are protected under Nevada Law: blood, breath or urine test results; communicable disease information, including information about sexually transmitted disease, including HIV and AIDS information about mental health treatment I have sought and/or received.

V. RELEASE FROM LIABILITY:

I hereby forever and finally release and discharge the above-named clinician and the University of Nevada, and any and all of its subsidiaries, affiliates, predecessors, successors, assigns, officers, directors, members, shareholders, employees, and agents, of and from any and all demands, actions, causes of action, claims, claims for relief, liens, costs and expenses of every kind and nature whatsoever, known and unknown, anticipated and unanticipated, suspected and unsuspected, past, present and future, either directly or indirectly, on account of, resulting from or to result from or in any manner growing out or arising from or connected in any way to this Authorization and Waiver and any activities conducted in accordance with it. In executing this document, I am relying wholly on my own judgment, and without reliance upon any statement, inducement or representation whatsoever regarding the matters contained herein by the persons and entities released hereby. No promise, inducement or representation has been made, offered or agreed upon in connection with my signing this document and I have carefully read this document and fully understand it. My signature is a free and voluntary act.

VI. ACKNOWLEDGEMENT OF MARKETING/FINANCIAL BENEFIT:

If this Authorization is for a marketing use or disclosure of my information, University of Nevada Las Vegas, School of Medicine, aka UNLV MED: [ ] will be [ ] will not be receiving financial benefit from a third party in connection with this Authorization.

I have been given a copy of this document. The signatures below are valid for one year.

_____ Date: _____

(Patient/Personal Representative signature)

If a personal representative, and not the patient, has signed this form, describe the personal representative's authority

(e.g., parent, guardian): _____

_____ Date: _____

(Witness signature)