UNLV HEALTH

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PLEASE PRINT PATIENT INFORMATION

LAST NAME:	**FIRST NAME:**	**MIDDLE:**
Date of Birth (MM/DD/YYYY):	Phone:	Email (optional):
Street Address:	City & State:	Zip Code:

PLEASE FILL IN INFORMATION AND CHECK ALL BOXES THAT APPLY

I authorize _____FAX # _____to release my medical information/records as indicated below:

☐ Progress Notes _____ ☐ Entire Medical Records _____

☐ Consultation Reports _____ ☐ Medication Records: _____

☐ Other (Please Specify) _____

☐ Date(s) of service from:_____ Date(s) of service to: _____

☐ Test Results ☐ Radiology Reports ☐ Laboratory Reports ☐ Pathology Reports ☐ Radiology Images

Records to be disclosed:

☐ Include HIV-related information ☐ Include Alcohol and Drug Abuse records ☐ Include Psychiatric Records ☐ Include Genetic Testing

I authorize the release of the information to:

Name: _____

Address: _____

Phone Number: _____ Fax # _____

☐ Healthcare Provider ☐ Insurance Company or Designee ☐ Attorney ☐ Court

☐ Law Enforcement ☐ Employer ☐ Other: _____

Reason for Disclosure ☐ Patient Request ☐ Benefits Application ☐ Other: _____

PLEASE CHECK REQUESTED FORMAT/MODE OF DELIVERY

☐ PAPER/MAIL ☐ PDF/EMAIL ☐ FAX

This authorization is effective beginning on the date I sign it and valid for one year from this date or until _____. It may be revoked at any time by providing a written notice of revocation to the Medical Records Department, except to the extent that the Providers have already taken action in reliance on it.
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 consent.
I understand that requests for medical record copies are subject to reproduction fees allowed by laws and regulations, and that I will have an opportunity to modify or withdraw my request if I do not want to pay those fees.
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.

SPECIFIC UNDERSTANDINGS

I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records and or HIV-related information (indicating that I have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or that could indicate that I have been potentially exposed to HIV).
If I am authorizing the release of HIV/AIDS, Alcohol or Drug treatment, or mental health treatment related information the recipient(s) is prohibited from redisclosing the information without my authorization unless permitted to do so under federal and state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization.
By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above. This information may be re-disclosed if the recipient(s) as described on this form is not required by law to protect the privacy Patient of the information and such information is no longer protected by federal health information privacy regulations.
Patient Signature: _____Date: _____
Personal Representative (Personal Representative to sign only if patient is a minor or unable to sign on his/her behalf)

Signature: _____

Print Name: _____ Phone Number_____