Authorization to Release Medical Records

(HIPAA Compliant Form)

Printed Name of Patient (First, Middle, Last name)	**Date of Birth (mm/dd/yyyy)**
Address (Street address, City, State, Zip Code)	
Phone Number	**E-mail**

Printed Name of Guardian or Legal Representative (First, Middle, Last name)	
Address (Street Address, City, State, Zip Code)	
Phone Number	**Fax Number**

I hereby authorize the following health care professional to release all health information about me:

Name of Health Care Provider/ Facility
Street Address

City	**State**	**Zip Code**
Phone Number		**Fax Number**

The following person/ organization is hereby authorized to receive/ send my entire medical record, treatment record, and diagnostic record:

Person/ Organization to Receive/ Send Information	AllCare for Women, LLC				
Street Address	1505 Wigwam Parkway, suite 241, Henderson, NV 89074				
City	Henderson	**State**	NV	**Zip**	89074

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Phone Number	702-852-3112	**Fax**	702-933-8705

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

The following health information that relates to service beginning from _____ to _____ may be released:

- Entire medical record including patient histories, office notes (excluding psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.

I further understand that my medical record may include one or more of the following:

- Treatment of communicable diseases including sexually transmitted diseases, venereal diseases, tuberculosis, and/ or hepatitis.
- HIV- related treatment
- Mental health information or psychological conditions
- Alcohol or substance abuse treatment
- Genetic testing

The above person/ organization, its employees, representatives and any other persons performing services for them on their behalf may need to obtain, use, or disclose any and all information about my physical and mental health, including but not limited to services for preventative, diagnostic, and therapeutic care, tests, counseling, and medical prescriptions for the purpose of:

- Change of Healthcare Provider
- Individual request
- Specialist referral
- Workers compensation
- Insurance purposes
- Continued treatment
- Other: _____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/ organization has relied on the use or disclosure of my health information.

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I have read (or have had read to me) this authorization and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient/ Personal Representative	**Date**	**Description of Personal Representative's Authority**