AUTHORIZATION FOR RELEASE OF INFORMATION

Family Doctors of Boulder City
895 Adams Blvd.
Boulder City, NV 89005
(702)293-0406 phone (702)293-0192 fax

Patient Information:

Name (please print):_____DOB:_____SS:_____

Information to be Released From: _____

Name of Designated Facility or Provider

_____

Address

_____ (_____)_____

City, State, Zip Code Phone Number

Information to be Sent To: _____

Name of Designated Facility or Provider

_____

Address

_____ (_____)_____

City, State, Zip Code Phone Number

Information to be Released:

- ☐ The most recent 2 years of pertinent information (i.e. Chart notes, labs, special tests)
- ☐ All medical records
- ☐ Specific information (Please specify):_____

_____

Purpose for which disclosure is being made (Please check one of the following):

- ☐ Attorney
- ☐ Doctor
- ☐ Insurance
- ☐ Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/Aids, sexually transmitted diseases, drug and/or alcohol abuse, mental abuse, or psychiatric treatment. I give my specific authorization for these records to be released.

~EXCLUDE the following information from the records released (please initial):

_____ Drug/Alcohol abuse/treatment and diagnosis
_____ HIV/AIDS diagnosis/treatment/testing
_____ Sexually Transmitted Disease
_____ Mental Illness or Psychiatric diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE:_____**DATE**:_____

Patient, Guardian*, or Authorized Representative*(*Please provide documents to prove authority to sign on behalf of the patient)

This authorization will expire 90 days from the date signed

Possible copying fee required