Southwest Medical Home Health

8655 S. Eastern Ave, Las Vegas, NV 89123 Fax: 242-7956

Authorization to Disclose Protected Health Information (PHI)

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

Patient Name: _____ 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): _____
(If Personal Representative, attach supporting documentation) *Date of Signature*

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