

AUTHORIZATION FOR THE RELEASE
OF PROTECTED HEALTH INFORMATION

TO:

PATIENT'S NAME:

This Authorization authorizes the release of Protected Health Information pursuant to 45 CFR Sections 160 and 164.

1. The undersigned authorizes the above-named provider ("Provider") to release the following information:

Any and all medical records, including, but not limited to, notes, memoranda, correspondence, telephone call records, pictures and/or videos, histories, narratives, summaries, conclusions, diagnoses, referrals, recommendations, prescriptions, imaging reports, test results, reference lab reports, physicians' and nurses' notes, Kardex, physical therapy and rehabilitation records and notes, including history, findings and observations, conclusions, x-ray readings and diagnoses, meylograms, CAT scans or MRI images, psychological and psychiatric records, records of other health care providers, and your prognosis as to subsequent or future development, or any other written documentation relating to the patient's treatment and/or care for the following time period:

to PRESENT

2. The information may be disclosed by employees or business associates of Provider.

3. The information may be disclosed to:

_____, or their duly authorized agents.

4. I understand and agree that the information to be disclosed includes the following types of information which are protected under Nevada or other federal law:

4.1 _____ blood, breath or urine test results.

4.2 _____ communicable disease information, including information about sexually transmitted disease, including HIV and AIDS.

4.3 _____ information about mental health treatment I have sought and/or received.

4.4 _____ information about drug and/or alcohol abuse treatment I have sought and/or received.

5. The disclosure may be made for the following purpose: ongoing litigation.

6. **This authorization will expire one year from the date this authorization is signed, or at the end of the litigation, whichever is last to occur.**

7. I further authorize the release of any and all medical billings, statements or invoices that you have in your possession, custody or control pertaining to my treatment and/or consultation.

8. I direct that a photocopy or facsimile of this authorization be accepted in lieu of the original.

9. I acknowledge: (1) that I have the right to revoke the authorization at any time, and (ii) that I understand that once the information is disclosed, it may no longer be protected by federal privacy law.

10. I acknowledge that I may revoke this authorization only in writing sent by certified mail to the Provider at the address above. The revocation shall be effective only upon receipt, except (1) to the extent the Provider has acted in reliance on the authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use the protected health information to lawfully contest a claim.

11. I understand that treatment by the provider is not conditioned on my signing this authorization, although exceptions will be made for (a) research-related treatment, (b) treatment the purpose of which is creating protected health information for a third party, such as pre-employment physicals, and (c) except for psychotherapy notes, for health plans which condition enrollment on an authorization requested prior to enrollment, or where payment is conditioned on an authorization to sue PHI to determine payment.

Date: _____

Signed by: _____

Patient's Name (Print): _____

Patient's SSN: _____

Patient's Date of Birth: _____

If person signing is other than patient, state authority under which signature is made:

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STATE OF NEVADA)
) ss:
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On the ____ day of _____, 2007, before me the undersigned, a Notary Public in and for said State personally appeared _____, known to me to be the person whose name is subscribed to the within instrument and acknowledged to me that he executed the same.

WITNESS my hand and official seal.

Notary Public In and For Said County and State