**Family Physicians of Southern Nevada**
**1470 E. Calvada Blvd., Suite 100**
**Pahrump, Nevada 89048**
**Telephone 775-751-6111**
**Fax 775-751-6115**

## Authorization to Receive Medical/Health Information

I, ____________________________________ authorize and request Family Physicians of Southern Nevada to **receive** the below specified information of (name) ___________________________________________ (date of birth) ___________________
(Social Security Number) ______________________________ who received services from Date) _____________________________to (Date)________________________________
(Name of Facility) __________________________________________________________
(Address) _________________________________________________________________

(Release to: (Name of Facility or Person) **Family Physicians of Southern Nevada**
Address **1470 E. Calvada Blvd., Suite 100**
City, State, Zip **Pahrump, Nevada 89048**

The purpose for this disclosure is: Follow up treatment Transfer/Treatment
Patient Request Eligibility Determination
Continuity of Care Legal Proceeding
Other ________________________________________

The Specific Information to be disclosed is:
Progress Notes Laboratory Results
X-Ray Reports Medication List
Diagnostic Study Results (specify):
_____________________________________________
Other (specify) ________________________________

1. **READ CAREFULLY**: I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing **Family Physicians of Southern Nevada** to receive my medical/health information. The protected health information (PHI) in my medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.
2. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing **Family Physicians of Southern Nevada to receive** any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information.
3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above named facility during the specified time frame.
4. This authorization becomes effective on (date) ________________________________.
This authorization automatically expires on the following date, event or special occasion:
_______________________________________________________________________
5. If I fail to specify a date, this authorization will expire in twelve (12) months.

6. 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 Privacy Officer at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will not be affected.
7. I understand that I have the right to receive a copy of this authorization. A photographic copy of this authorization is as valid as the original.
8. I understand that authorizing **Family Physicians of Southern Nevada to receive** this medical/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 request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR, Section 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 medical/health information, I can contact the Privacy Officer for this covered entity.
9. **THE FOLLOWING STATEMENT APPLIES TO ANY ALCOHOL, AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS THAT WE DISCLOSE:** Prohibition on redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize **Family Physicians of Southern Nevada** to receive my Protected Health Information.

Signature of Patient: _____________________________________ Date: ____________________

Signature of Witness: ____________________________________ Date: ____________________

Signature of Parent/
Guardian/Legal Rep. _____________________________________ Date: ____________________

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## NOTICE OF REVOCATION

I, ____________________________________, hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

Signature of Patient: _____________________________________ Date: __________________

Signature of Witness: ____________________________________ Date: __________________

Signature of Parent/
Guardian/Legal Rep: _____________________________________ Date: ___________________