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Nevada Heart & Vascular Center Medical Records Release Form

Patient Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

I authorize the use and disclosure of the above named individual's health information as described below. The following individuals or organization is authorized to make a disclosure:

The type and the amount of information to be used or disclosed is as follows: *(include dates where applicable)*.

	FROM	TO
<input type="checkbox"/> Problem List	_____	_____
<input type="checkbox"/> Medication List	_____	_____
<input type="checkbox"/> List of Allergies	_____	_____
<input type="checkbox"/> Immunization List	_____	_____
<input type="checkbox"/> Most Recent History & Physical	_____	_____
<input type="checkbox"/> Most Recent Discharge	_____	_____
<input type="checkbox"/> Laboratory Results	_____	_____
<input type="checkbox"/> X-Rays & Image Reports	_____	_____
<input type="checkbox"/> Consultation Reports	_____	_____
<input type="checkbox"/> Entire Record	_____	_____
<input type="checkbox"/> Other _____	_____	_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). This information may be disclosed to Nevada Heart & Vascular and all its physicians and entities. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present this revocation to the health information management department. I understand that this revocation does not apply to information already released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____
 If I fail to specify an expiration date, event, or condition, this authorization will expire in 6 months.

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 I may inspect a copy of the information to be disclosed as provided in the CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

If I have questions about disclosure of my health information, I can contact Nevada Heart and Vascular Medical Records Department.

 Signature of Patient or Legal Representative

 Date