MEDICAL RECORDS RELEASE FORM

Patient First Name	Patient Last Name	DOB MM/DD/YYYY	SSN xxx-xx-xxxx

Patient Address	City	State	Zip Code

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

_____

_____

_____

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

AUTHORIZED	CATEGORY	DATE FROM	DATE TO
☐ Yes ☐ No	Problem List		
☐ Yes ☐ No	Medication List		
☐ Yes ☐ No	Allergies List		
☐ Yes ☐ No	Immunization List		
☐ Yes ☐ No	Most recent history and physical		
☐ Yes ☐ No	Most recent discharge		
☐ Yes ☐ No	X-Rays and other Image Reports		
☐ Yes ☐ No	Laboratory Reports		
☐ Yes ☐ No	Consultation Reports		
☐ Yes ☐ No	Entire Record		
☐ Yes ☐ No	Other Records:		

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 and Vascular Center (NHVC) and all its physicians and entities. I understand I have the right to revoke this authorization, I must do so in writing and present this revocation to the Medical Records department. I understand this revocation does not apply to information already released in response to the 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 other revoked, this authorization will expired on the following date, event or following condition:

Condition: _____.

If I fail to specify an expiration date, event, or condition, this authorization will expire in one year. 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 NHVC Medical Records Department.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Legal Representative, Relationship to Patient Date

MR 400.005