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
○	**Problem List**	_____	_____
○	**Medication List**	_____	_____
○	**List of Allergies**	_____	_____
○	**Immunization List**	_____	_____
○	**Most Recent History & Physical**	_____	_____
○	**Most Recent Discharge**	_____	_____
○	**Laboratory Results**	_____	_____
○	**X-Rays & Image Reports**	_____	_____
○	**Consultation Reports**	_____	_____
○	**Entire Record**	_____	_____
○	**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

_____ _____
Legal Representative, Relationship to Patient Signature of Witness