Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Name:_____ Patient DOB:_____
Address:_____ City:_____ State:_____ Zip: _____

I authorize the use or disclosure of the above named individual's PHI to be released as follows:
__All Medical Records __Lab/X-ray _Other_____
Reason for Request:
__Medical Care _Personal Insurance _Attorney____Other_____

This authorization is given and to remain in force for the specified period:
__From_____to_____
__For the period of 1 year beginning on: _____

The following named individuals are granted permission to access my medical information and communicate on my behalf:

Name:_____ Relationship:_____
Name:_____ Relationship: _____

Transfer Records From:
Name: _____
Address:_____ City:_____ State:_____ Zip: _____
Phone Number:_____ Fax Number: _____

Send Records To:
Name: _____
Address:_____ City:_____ State:_____ Zip: _____
Phone Number:_____ Fax Number: _____

Signature of Patient, Parent, Guardian or Personal Representative:
Signature:_____ Date: _____
Print name of above:_____ Relationship to Patient: _____

8352 W. Warm Springs Rd., 3rd Floor, Las Vegas, NV
Office: (702)851-7287 Fax: (702)851-7286