Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below, consistent with Nevada and Federal law concerning the privacy of such information.

FAILURE TO PROVIDE ALL INFORMATION REQUESTED MAY INVALIDATE THIS AUTHORIZATION.

Name of Patient: _____ Date of Birth: ____ / ____ / _____

INFORMATION TO BE RELEASED FROM:

The DOCS
8352 W Warm Springs Rd Suite 300 Las Vegas NV 89113
Phone # (702) 851-7287 Fax # (702) 851- 7286

INFORMATION TO BE PROVIDED TO: ***(MUST BE FILLED IN COMPLETELY)***

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please Note: A fee will be charged for providing records. Pages 1+: $0.60 per page. Fee will be due at the time of pick up or before records are mailed.

I would like: ☐ Paper ☐ ☐
Deliver Method: ☐ Mail

Email Address: _____

Please release the following information: check requested items

☐ Discharge Summary
☐ History & Physical
☐ Operative Report
☐ Consultations
☐ Radiology Reports
☐ Radiology Images
☐ Laboratory Reports
☐ Other: _____
☐ Immunization Records
☐ Nurses' Notes
☐ Ambulatory Clinic
☐ Specialty Clinic _____
☐ Emergency Room Report
☐ Pertinent Information (all reports, radiology, labs, etc.)

Dates of Treatment: _____

CONTINUED ON REVERSE SIDE

PATIENT ID

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Purpose of requested use of disclosure:

☐ Patient/Parent Request ☐ Continuing Care ☐ Legal
☐ Insurance ☐ Other _____

This authorization expires:

☐ From the date of this authorization until ____/____/_____ (date must be specified)
☐ Until The DOCS Fulfill the request.
☐ Until the following even occurs (must be specific): _____

- Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
- I may revoke this authorization at any time. My revocation must be in writing and forwarded to The DOCS.
- My revocation will be effective upon receipt but will not be effective if The DOCS has already processed original request for release of health information.
- I understand that I may inspect or obtain copies, for a fee, of the health information that is being released.
- I understand that once the above information is released the recipient may redisclose it and the information may not be protected by federal privacy laws or regulations.

I have a right to receive a copy of this authorization.
Copy Requested: ☐ Yes ☐ No Initial: _____ Date: ____/____/_____

DISCLOSURES REQUIRING SPECIAL CONSENT:
My signature below also specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for (please initial):

_____HIV/AIDS Virus _____Mental Health/Psychiatric Disorders
_____Sexually Transmitted Diseases _____Drug, Alcohol Abuse/Treatment

_____ ____/____/_____
Signature of Patient/Parent/Legal Guardian Date

_____ _____
Printed Name of Patient/Parent/Legal Guardian Relationship to Patient

_____
Phone Number

OFFICE USE ONLY:

ROI PROCESSED BY (PRINTED NAME): _____

DATE: ____/____/_____ **MRN:** _____