

**Authorization for the Release of Health Information**

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Sex: M F

Parent(s) or Legal Guardian(s): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street  
 \_\_\_\_\_ E-mail: \_\_\_\_\_  
City State Zip

**I consent to the release of protected health information indicated below:**

All  Office Reports  Hospital Reports  Surgery Reports  Ekg/Echo  Labs  Other \_\_\_\_\_

**The purpose for such disclosure is:**

My request (only parent/patient)  Payment/Insurance  Healthcare  Employment  Other \_\_\_\_\_

**The information is to be released  to  from:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

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 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

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 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

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 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

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 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**I understand this authorization is effective beginning on the date I sign it. It may be revoked at any time, except to the extent the provider has taken action in reliance upon it, by delivering written notice to the HIM Manager at Children's Heart Center. The revocation will be effective as of the date received. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand my refusal to sign will in no way affect my treatment. This authorization expires: \_\_\_\_\_**

\_\_\_\_\_  
 Patient or Parent/Guardian Signature

\_\_\_\_\_  
 Relationship to Patient

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date

**All items on this authorization must be completed in full or the request will not be honored.**

**Southern Nevada**  
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