Authorization for the Release of Health Information

I hereby authorize _____ to release the protected health information of:

Patient: _____ Date of Birth _____/_____/_____
Address: _____ Phone ( ) _____

The information is to be released □ to □ from:

Name: _____ Phone ( ) _____
Address: _____ Fax ( ) _____
Email Address: _____

The information I wish to have release is (include dates of service): _____

□ Office Notes □ Ekg/Echo □ Labs □ X-ray □ Hospital Reports □ Surgery Reports □ Other_____
I do ____ I do not ____ wish to have information about HIV/AIDS released under this authorization.

The purpose for such disclosure is:

□ At my request (only parent/patient may check) □ Payment/Insurance □ Healthcare □ Employment
□ Other_____

This authorization will expire one year from the date it is signed unless a shorter time is indicated here: _____

♥ I understand that this authorization may be revoked by me at anytime except to the extent that action has been taken in reliance upon it.
♥ The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

_____ _____ _____/_____/_____
Patient or Parent/Guardian Signature Relationship to Patient Date

This authorization form is designed to meet the requirement of federal privacy regulations issued by HIPAA.
All items on this authorization must be completed in full or the request *will not* be honored.

Telephone (702) 732-1290 ♥ Toll Free (866) 732-1290 ♥ Facsimile (702) 732-1385 ♥ Email: medicalrecords@childrensheartcenter.com
Southern Nevada Main Office: 3006 South Maryland Parkway Ste 690, Las Vegas, NV 89109
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