Childrens Heart Center Nevada all hearts

continuous care for the fetus, child & adult with congenital heart disease

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: _____________________

Name: _____________________________________ Phone: ____________________ Fax: ____________________

Address: ____ E-mail Address: _____________________

Name: _____________________________________ Phone: ____________________ Fax: ____________________

Address: ____ E-mail Address: _____________________

Name: _____________________________________ Phone: ____________________ Fax: ____________________

Address: ____ E-mail Address: _____________________

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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