

# Cardiovascular Surgery of Southern Nevada

## Authorization for Release of Information

PATIENT NAME: \_\_\_\_\_  
LAST FIRST MI MAIDEN OR OTHER NAME  
DATE OF BIRTH: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ MEDICAL RECORD #: \_\_\_\_\_  
MO DAY YR  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_  
DAY PHONE: \_\_\_\_\_ EVENING PHONE: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ (Print Name of Provider) to release information from my medical record as indicated below to:

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_  
DAY PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

### INFORMATION TO BE RELEASED:

DATES: \_\_\_\_\_  
 History and physical exam \_\_\_\_\_  
 Progress notes \_\_\_\_\_  
 Lab reports \_\_\_\_\_  
 X-ray reports \_\_\_\_\_  
 Other: \_\_\_\_\_  
\_\_\_\_\_

I specifically authorize the release of information relating to:  
 Substance abuse (including alcohol/drug abuse)  
 Mental health (including psychotherapy notes)  
 HIV related information (AIDS related testing)  
X \_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

**PURPOSE OF DISCLOSURE:**  Changing physicians  Consultation/second opinion  Continuing care  
 Legal  School  Insurance  Workers Compensation  
 Other (please specify): \_\_\_\_\_

- I understand that this authorization will expire 90 days after I have signed the form.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand that if I am being requested to release this information by \_\_\_\_\_ (Print Name of Provider) for the purpose of: \_\_\_\_\_
  - by authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
  - I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
  - I have been informed that \_\_\_\_\_ (Print Name of Provider)  will/  will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
- I understand that in compliance with Nevada statute, I will pay a fee of 60¢ per page copied and the cost of postage to mail the records.

\_\_\_\_\_  
SIGNATURE OF PATIENT DATE \_\_\_\_\_ OR \_\_\_\_\_  
PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

\_\_\_\_\_  
RECORDS RECEIVED BY DATE \_\_\_\_\_ RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY  
DATE REQUEST FILLED: \_\_\_\_\_ BY: \_\_\_\_\_  
IDENTIFICATION PRESENTED: \_\_\_\_\_ FEE COLLECTED: \$ \_\_\_\_\_