CARDIOVASCULAR SURGERY OF SOUTHERN NEVADA

AUTHORIZATOIN FOR RELEASE OF MEDICAL RECORDS

(Please read carefully)

Per HIPAA (Health Insurance Portability and Accountability Act) we are unable to release your information without your authorization. If a person known to you calls to request information including appointment times and they are not listed below, we are unable to provide them with any information.

The following persons are allowed to receive my information and care provided by CSSN:

(Do not list your physicians or insurance information here)

Name:_____________________________________Relationship:_________________Phone#:____________

Name:_____________________________________Relationship:_________________Phone#:____________

Name:_____________________________________Relationship:_________________Phone#:____________

Name:_____________________________________Relationship:_________________Phone#:____________

Name:_____________________________________Relationship:_________________Phone#:____________

Name:_____________________________________Relationship:_________________Phone#:____________

Name:_____________________________________Relationship:_________________Phone#:____________

Patient Name(Print):____

Patient/Guardian Signature:____ Date:_______________

Revised 11/01/16