Nevada Health Centers, Inc.
RELEASE OF MEDICAL INFORMATION

Nevada Health Centers Support Services Department
4045 Spencer Street, Suite 105, Las Vegas, NV 89119
Phone: 702.941.5201 | Fax: 702.399.2496

Patient name ______________________ Date of birth ____________
Nombre del paciente *Fecha de nacimiento*

I authorize release of the above named patient's Healthcare Information ☐ To or ☐ From:
Autorizo la revelación de la información sobre atención médica del paciente arriba nombrado: (Para o De)

Name *(Nombre)* ______________________

Address *(Dirección)* ______________________

Phone *(Teléfono)* ______________________ Fax ______________________

Check ONLY Required Records:

☐ Medication List ☐ Immunization Records ☐ Provider Notes
☐ Laboratory Results ☐ X-Ray ☐ Billing Records
☐ Other ______________________

☐ Healthcare records covering the period of ____________ (date) to ____________ (date)
Expedientes de atención médica que cubre el período de (fecha) a (fecha)

Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.

I ☐ DO ☐ DO NOT authorize release of confidential information concerning:
Yo autorizo que se compartan los expedientes listados arriba aunque estos expedientes contengan información acerca de (ponga iniciales si aplica):

☐ Yes ☐ No Acquired Immunodeficiency Syndrome (AIDS) / Human Immunodeficiency Virus (HIV) infection
Síndrome de inmunodeficiencia adquirida (SIDA) / Infección por el virus de la inmunodeficiencia humana (VIH)

☐ Yes ☐ No Behavioral health / mental health / psychiatric testing, diagnosis, history and/or treatment
Salud conductual / salud mental / pruebas psiquiátricas, diagnóstico, historia o tratamiento

☐ Yes ☐ No Alcohol or drug testing, diagnosis, history, and/or treatment
Pruebas de consumo de alcohol o drogas, diagnóstico, historia o tratamiento

☐ Yes ☐ No Social Services
Servicios sociales

Reason For Request: (Please check one) *Motivo de la petición: (Marque uno)*

☐ Medical Care ☐ Insurance ☐ Personal ☐ Attorney ☐ Other ______________________

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to a Nevada Health Centers location. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

______________________ IF LEFT BLANK, THIS AUTHORIZATION WILL EXPIRE IN 120 DAYS.

Patient or Authorized Guardian Signature ______________________
(Firma del paciente o del tutor autorizado)

Date *(Fecha)* ____________ Witness *(Testigo)* ______________________

For Office Use Only:

Request completed by ______________________ Date ____________
(NVHC Staff member signature)