NEVADA HEALTH CENTERS

Nevada Health Centers, Inc. WIC
RELEASE OF MEDICAL INFORMATION

- ☐ WIC Bonanza: 5001 E. Bonanza Road, Suite 104, Las Vegas, NV 89110 / Phone 702.220.9930 / Fax 702.438.1262
- ☐ WIC Cambridge: 3900 Cambridge Street, Suite 202, Las Vegas, NV 89119 / Phone 702.220.9934 / Fax 702.369.2511
- ☐ WIC Decatur: 5085 W. Sahara Avenue, Suite 134, Las Vegas, NV 89146 / Phone 702.220.9944 / Fax 702.870.1896
- ☐ WIC Gowan: 3650 N. Rancho Drive, Suite 101, Las Vegas, NV 89130 / Phone 702.220.9926 / Fax 702.631.4394
- ☐ WIC MLK: 1700 Wheeler Peak Drive, Las Vegas, NV 89106 / Phone 702.220.9928 / Fax 702.293.0482
- ☐ WIC NLV: 2225 Civic Center Drive, Suite 150, North Las Vegas, NV 89030 / Phone 702.220.6096 / Fax 702.399.3692
- ☐ WIC Tropicana: 5486 Boulder Highway, Suite 102, Las Vegas, NV 89122 / Phone 702.220.9929 / Fax 702.433.7823

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)