Nevada Health Centers, Inc.
RELEASE OF MEDICAL INFORMATION

Nevada Health Centers Medical Records Department
1799 Mount Mariah Drive, Las Vegas, NV 89106
Phone: 702.941.5201 | Fax: 702.399.2496

Patient name: _____ Date of birth: _____

I authorize release of the above named patient's Healthcare Information ☐ To or ☐ From:

Name: _____

Address: _____

Phone: _____ Fax: _____

Check ONLY Required Records:
☐ Medication List ☐ Immunization Records ☐ Provider Notes
☐ Laboratory Results ☐ X-Rays ☐ Billing Records
☐ Other _____

☐ Healthcare records covering the period of _____ *(date)* to _____ *(date)*

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 authorize release of confidential information concerning:

☐ Yes ☐ No Acquired Immunodeficiency Syndrome (AIDS) / Human Immunodeficiency Virus (HIV) infection
☐ Yes ☐ No Behavioral health / mental health / psychiatric testing, diagnosis, history and/or treatment
☐ Yes ☐ No Alcohol or drug testing, diagnosis, history, and/or treatment
☐ Yes ☐ No Social Services

Reason For Request: *(Please check one)*

☐ 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: _____

Date: _____ Witness: _____

For Office Use Only:

Date faxed: _____ Patient MRN: _____

Request completed by: _____ Date: _____
(NVHC Staff member signature)