NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
AUTHORIZATION TO SHARE INFORMATION

Patient Name *(please print)*: _____ Date: _____

Date of Birth *(mm/dd/yyyy)*: _____ MRN *(office use only)*: _____

Our Notice of Privacy Practices (FD-ALL.014e) provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights Section describing your right to authorize a member of your family, friend or a designated individual of your choosing to discuss your protected health information. You have the right to terminate this authorization at any time by completing this form and checking the "I want to terminate…" section below, otherwise your authorization will not expire.

☐ **I authorize the following persons or entities to represent me or contact you and request information:**

☐ **I want to terminate my authorization to disclose information from the following person/entities:**

☐ **None selected or none named**

Name *(please print)*	Relationship	Date of birth	Phone number

If you are signing for a minor child, please enter your name above, as well as any other parent or guardian who has your authorization for us to share information with them.

The persons named above can request the following information:

☐ **Medication refills** ☐ **Referrals** ☐ **All information pertaining to appointments** ☐ **All medical information**

_____ _____

Patient Signature (Parent/legal guardian signature if patient is under 18 years old) Date

_____

Print Signature Name (if parent/legal guardian)