EPITOMEDICAL.

George Med-Peds Associates, P.C.
PO Box 82227
Las Vegas, Nevada 89180-2227

AUTHORIZATION TO RECEIVE PROTECTED HEALTH INFORMATION FROM OTHER FACILITIES

MEDICAL RECORDS FAX NUMBER: 702-433-5410

PATIENT INFORMATION

I authorize George Med-Peds Associates, P.C. to receive Protected Health Information (PHI) from the health records of:

Patient Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Medical Record Number: _____ SSN: _____

Date of Birth: _____ Date of Requested Treatment(s): _____

MEDICAL RECORDS BEING REQUESTED FROM:

Name of Person or Facility: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____ Date Requested: _____

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED

Please check all that apply.

- ☐ Face Sheet
- ☐ Discharge Summary
- ☐ History and Physical Exam
- ☐ Operative Reports
- ☐ X-ray / Diagnostic Reports
- ☐ Lab Tests
- ☐ Pathology Reports
- ☐ Consultations
- ☐ Other (Specify): _____
- ☐ Hospital Admission Evaluation(s)
- ☐ Social Work Evaluation(s)
- ☐ Nursing Assessment(s)
- ☐ Treatment Plan(s)
- ☐ Progress Notes - Inpatient
- ☐ Progress Notes - Outpatient
- ☐ Mental Health Assessments/Evaluations
- ☐ Verbal Communication

SPECIFIC DESCRIPTION OF THE PURPOSE OF THE DISCLOSURE

Please check all that apply.

- ☐ Continued Patient Care
- ☐ Workers' Compensation
- ☐ Other (Specify): _____
- ☐ Insurance Coverage or Payment for Care
- ☐ Disclosure is at Patient's Request

I AUTHORIZE THE PROVIDER TO USE OR DISCLOSED INFORMATION RELATED TO:

(Requested fields require an initial)

_____ AIDS / HIV and other Communicable Disease(s) (May not be redisclosed by recipient without additional consent)

_____ Behavioral Health Care / Psychiatric Care

_____ Alcohol and / or Drug Abuse Treatment

_____ Genetic Testing Information

_____ **I CONSENT TO THE RELEASE OF INFORMATION CREATED WITHIN 24 MONTHS AFTER THE DATE THIS AUTHORIZATION WAS SIGNED.**

I understand that **George Med-Peds Associates, P.C.** will not condition treatment on my signing this authorization. They will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I understand that I may revoke this authorization at any time, unless the disclosing party has already relied on my authorization to disclose health information. To revoke my authorization, I must submit a written request to Medical Records. Unless I revoke this authorization earlier, it will expire twenty four months from date of signature. I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person/organization that receives the information. I understand the matters discussed on this form. **I release George Med-Peds Associates, P.C., Southern Nevada Internal Medicine / Pediatrics, Epitomedical and their providers, their employees, officers and directors, medical staff members and business associates** from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Patient Signature: _____ Witness: _____ Date: _____

(If someone other than the patient has authority to sign for the patient, please complete our Non-patient Authorization Form)