EPITOMEDICAL.

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

NON-PATIENT REPRESENTATIVE AUTHORIZATION TO RELEASE / RECEIVE PROTECTED HEALTH INFORMATION

MEDICAL RECORDS FAX NUMBER: 702-433-5410

PATIENT INFORMATION AND RELATIONSHIP

If You Are Not the Patient and Have Authority to Sign for the Patient, Please Complete the Following:

Patient Name: _____ Patient Date of Birth: _____

Your Name: _____

Your Relationship to the Patient: _____

AUTHORITY TO RELEASE / RECEIVE THE PATIENT'S INFORMATION

Please check the applicable option.

- ☐ Written patient authorization (see other side)
- ☐ You are the patient's parent or guardian
- ☐ You are the patient's health care decision maker
  (If this is the case, please attach evidence such as medical power of attorney)
- ☐ The patient is deceased, and you are the personal representative of the patient's estate
  (If this is the case, please attach evidence)
- ☐ Other (Specify): _____

INFORMATION DELIVERY METHOD

Please check the applicable option.

- ☐ I will pick up the records at George Med-Peds Associates, P.C. 8859 West Flamingo Road, Las Vegas, NV 89147
- ☐ Other (Specify): _____

- I will review my original records onsite in the Medical Records Department and I will call them at (702) 419-3482 to schedule a time.
- I am authorized to receive copies of the medical records for the above named patient and have legal authority to sign this authorization form.

Your Signature: _____ Date: _____