GEORGE MED-PEDS ASSOCIATES, P.C.
PO BOX 82227
LAS VEGAS, NEVADA 89180-2227

MEDICAL RECORDS FAX NUMBER:
702-433-5410

AUTHORIZATION TO RECEIVE PROTECTED HEALTH INFORMATION FROM OTHER FACILITIES

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 treatment(s) requested:** _____

- 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:

O	FACE SHEET	**O**	HOSPITAL ADMISSION EVALUATION(S)
O	DISCHARGE SUMMARY	**O**	SOCIAL WORK EVALUATION(S)
O	HISTORY AND PHYSICAL EXAM	**O**	NURSING ASSESMENT(S)
O	OPERATIVE REPORTS	**O**	TREATMENT PLAN(S)
O	X-RAY / DIAGNOSTIC REPORTS	**O**	PROGRESS NOTES - Inpatient
O	LAB TESTS	**O**	PROGRESS NOTES - Outpatient
O	PATHOLOGY REPORTS	**O**	MENTAL HEALTH ASSESMENTS/EVALUATIONS
O	CONSULTATIONS	**O**	VERBAL COMMUNICATION
O	OTHER (SPECIFY):		

SPECIFIC DESCRIPTION OF THE PURPOSE OF THE DISCLOSURE:

O	CONTINUED PATIENT CARE	**O**	WORKERS' COMPENSATION	**O**	INSURANCE COVERAGE OR PAYMENT FOR CARE
O	DISCLOSURE IS AT PATIENT'S REQUEST	**O**	OTHER(SPECIFY):		

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.

_____ _____ _____
SIGNATURE OF PATIENT **DATE** **WITNESS**

(IF SOMEONE OTHER THAN PATIENT HAS AUTHORITY TO SIGN FOR THE PATIENT, SEE NON-PATIENT AUTH FORM)