

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

MEDICAL RECORDS FAX NUMBER:
702-433-5410

MEDICAL RECORD RELEASE AUTHORIZATION FORM

I authorize George Med-Peds Associates, P.C. to disclose 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) to be released:** _____

- SEND MEDICAL RECORDS TO -

Name of Person or Facility: _____
Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone Number: (____) _____ **Fax Number:** (____) _____ **Date Sent:** _____

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:

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

SPECIFIC DESCRIPTION OF THE PURPOSE OF THE DISCLOSURE:

<input type="checkbox"/>	CONTINUED PATIENT CARE	<input type="checkbox"/>	WORKERS' COMPENSATION	<input type="checkbox"/>	INSURANCE COVERAGE OR PAYMENT FOR CARE
<input type="checkbox"/>	DISCLOSURE IS AT PATIENT'S REQUEST		<input type="checkbox"/>	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 re-disclosed 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)