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

**MEDICAL RECORDS FAX NUMBER:**
**702-433-5410**

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

**IF YOU ARE NOT THE PATIENT AND HAVE AUTHORITY TO SIGN FOR THE PATIENT, PLEASE COMPLETE THE FOLLOWING:**

Patient's Name: _____ Patient's Date of Birth: _____

What is your name? _____

Your relationship to above noted patient? _____

**What gives you the authority to release / receive the patient's information? (please select)**

_____ 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 (please specify): _____

**Method of delivering information:**

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

_____ Other (please specify): _____

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- 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.

_____ _____
**SIGNATURE** **DATE SIGNED**

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