Mail, email, or fax completed form to:
Southern Nevada Health District 280 S. Decatur Blvd., Las Vegas, NV 89107
medicalrecordsrequest@snhd.org / Fax: (702) 759-1412/Tel: (702) 759-1700

Authorization to Disclose Patient Health Information

For Office Use Only:
Approved: _____
Date: _____

Patient (please print): _____ Male/Female (circle one) Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ or e-mail address: _____

I authorize the disclosure of the above-named individual's Protected Health Information (PHI) and request the **Southern Nevada Health District/Community Health Center** release the requested information to: *(Note: There is a fee of $0.60 per page for hard copies)*

Name (please print): _____

Address: _____

Release of Information may be: _____mailed; or faxed to **secure** fax number _____; or call this number _____ for in-person pickup; or sent via encrypted email to: _____

The purpose for this requested information is for:
☐ Continuity of Care ☐ Personal Use ☐ School ☐ Attorney ☐ Insurance ☐ Other, Specify: _____

SPECIFY DATES OF SERVICES, IF KNOWN: _____

The following information is requested:

☐ Immunization Records
☐ Primary Care Records
☐ Family Planning Records
☐ Behavioral Health Records
☐ Disease Investigation Records
☐ TB Clinic Records
☐ Refugee Clinic Records
☐ Lab Test (specify type of test): _____
☐ Complete Medical Record
☐ Other, specify: _____

I acknowledge and hereby understand that releasing my health records may contain information relating to HIV or AIDS, treatment for alcohol and/or drug abuse, and/or sexually transmitted disease.
I CONSENT TO THE RELEASE OF: ☐ HIV or AIDS (Ryan White) Records ☐ Treatment for Alcohol and/or Drug Abuse Records and/or ☐ Sexually Transmitted Disease Records. _____ *(INITIALS).*

This authorization will expire on the following date or event: _____ or 180 days from date of signature if I do not specify.

I understand that:
1. Authorizing this release of information is voluntary and I may refuse to sign this authorization.
2. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization except where the treatment is for the purpose of research or solely for purpose of creating a health record for disclosure to a third party.
3. I may revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it.
4. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy regulations.

The Southern Nevada Health District, its employees and healthcare providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient or Patient's Legal Representative **Today's Date**

_____ _____
Print Name of Legal Representative (if applicable) **Relationship to Patient**

Note: *Guardians and Durable Power of Attorney designees must include a copy of the applicable paperwork.*
Digital signatures are not accepted without a valid digital signature certificate.
This authorization is not valid for the release of psychotherapy notes.