Independent Medical Group
1320 E Calvada blvd
Pahrump, NV 89048

Authorization to Disclose Protected Health Information

This request to obtain medical records will be returned if not completed in its entirety.

Patients name:____DOB:____________

Address:______________________City:____________State:________Zip:________

I HEARBY AUTHORIZE____

____
address city, state,zip

______________________ ______________________
Phone fax

include dates where appropriate From:(date) 1st visit To:(date) Current

X Entire record, or

_______Medication list_Immunization Record _______Provider Notes

_______lab results _______X-ray/ Dexa Reports __Cardiology Reports

Other:____

If present, I Give Permission to Release Any Sensitive Information Regarding(Initial On applicable lines Below)

_______Substance Abuse_______Phychiatric/Mental Health Information__HIV information

_______Genetic Test Result_______Child & Domestic Abuse History____Addictive Behavior

_______Communicable and Sexually Transmitted Disease

Reason for request: Continuing Medical Care

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re disclosure and the information may not be protected by federal confidentially rules. If I have any questions about disclosure of my health information, I can contact Health Information Management Department and obtain a copy of the privacy Notice.

This Information to be disclosed to :

Independent Medical Group
1320 E Calvada
Pahrump, NV 89048

phone: (775)751-6111
Fax: (775)751-3056

Signature of Patient:

____
Date of signature

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I fail to specify an expiration date this authorization will expire in six months from the date of this request.