

REQUEST FOR RELEASE

Name of Patient: _____ Date of Birth: _____ SS# _____

I HEREBY AUTHORIZE THE RELEASE OR REVIEW OF THE FOLLOWING INFORMATION FROM AND TO THE PARTIES NAMED HERE.

FROM: _____
Facility of Physicians's

Address

City, State, Zip Code

Phone Number

TO: ***Integrative Medicine of Nevada*** _____
Facility or Physician's name
4600 Kietzke Ln., Ste. I-206 _____
Address
Reno, NV 89502 _____
City, State, Zip Code
775-827-2449 (fax: 827-1219) _____
Phone Number

What date of service do you want released? _____

Information to be released: (Pt must initial each item to be released)

____ discharge summary ____ history and physical ____ laboratory tests ____ xray and ekg
____ consultation notes ____ progress notes
____ Other, please be specific: _____

Reason for release of records: _____

Expiration Date: This authorization is good until _____, or for 90 days from the date signed unless revoked by me in writing and submitted to the privacy officer at Integrative Medicine of Nevada.

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information could be redisclosed without my authorization.

I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization.

I understand that I have a right to inspect or receive a copy of this authorization. Copy requested and received:
____ NO ____ YES INITIAL: _____

I release the person/agency, disclosing this information from any liability arising from the release of information to the person/agency designated above.

NOTICE - RELEASE OF ALCOHOL AND DRUG ABUSE RECORDS: The Federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of Patient

Date

Signature of Guardian/Representative

Date

Signature of Witness

Date