AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

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

A. Person(s) or Organization(s) authorized to provide the information:

( ) Desert Pediatrics
7180 Cascade Valley Ct. #180
Las Vegas, NV 89128
Phone (702) 641-2150
Fax (702) 228-1043

( ) Desert Pediatrics
2150 S. Eastern Avenue
Las Vegas, NV 89104
Phone (702) 641-2150
Fax (702) 641-8667

B. Person(s) or Organization(s) authorized to receive the information:

Name of Person/Facility to receive:
Fax Number:
Email address:

C. Specific description of the information that may be used or disclosed (including date(s))

D. Specific description of how the information will be used:

E. Charge for copy of health information (please circle your choice)

Paper Copies $.60 per page CD Copy $20.00

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1) I understand that this authorization will expire on _____ (insert date).
2) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Desert Pediatrics in writing.
3) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may inspect or copy any information or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would not longer be protected by these regulations.

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

NOTE:
You have the right to know specifically what information you are authorizing for release (e.g. "results of a lab test performed on 01/04/03" or, if your entire medical record is included, "all health information.")
You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g. the names of your health care provider(s)).
You have the right to know who is going to use it and what it is going to be used for. (e.g. John Smith, PhD/Research)

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM