

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:

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

<input type="checkbox"/> Desert Pediatrics 7180 Cascade Valley Ct. #180 Las Vegas, NV 89128	Phone (702) 641-2150 Fax (702) 228-1043	<input type="checkbox"/> Desert Pediatrics 2150 S. Eastern Avenue Las Vegas, NV 89104	Phone (702) 641-2150 Fax (702) 641-8667
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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:

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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

HIPPA Authorization for Release of Information

This form does not constitute legal advice and covers only federal, not state, laws.