PREFERRED FAMILY MEDICINE
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AUTHORIZATION TO OBTAIN HEALTH INFORMATION

1. **Name of Patient:**______________________________
   Email:______________________________
   Birth Date: ______________________________
   Street Address: ______________________________
   City, State, Zip: ______________________________

2. **Information Request From:**

   Primary Care Doctor: ______________________________
   Phone Number/Location:______________________________

   Cardiac (Cardiologist, Echocardiogram, Coronary Calcium Score, Stress Test):
   Physician Name/Location: ______________________________
   ____

   Preventative (Mammo, PAP, Colonoscopy or Cologuard, Bone Density):
   Physician Name/Location:______________________________
   ____

   Imaging (Reno Diagnostic, Renown, Northern Nevada, Etc):
   Name of Imaging Place: ______________________________
   Location: ______________________________

   Vaccines:
   Which state were the majority vaccines completed?______________________________

   Specialist (Urologist, Gynecologist Etc):
   Physician Name/Location: ______________________________

   Lab (Labcorp, Quest, Etc)
   Name/Location:______________________________

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3. Information to be obtained:

- o Discharge Summary
- o Lab Results
- o Consultations
- o History & Physical
- o Immunization Records
- o Physician Progress Notes
- o Other:
- o Medication Lists
- o Problem List
- o List of Allergies
- o X-Ray Reports
- o Physician Orders
- o Entire Record

In compliance with the Nevada Mental Health Procedures Act:
___ Copies of medical records pertaining to diagnosis and/or treatment of psychiatric, psychological conditions and/or drug or alcohol abuse may be released to the recipient as noted above.

___ Copies of medical records, including information of the diagnosis and/or treatment for AIDS/HIV (including testing) may be released to the recipient as noted above.

4. 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 may be redisclosed without obtaining my authorization.

5. Your Rights with Respect to This Authorization:
·Right to Receive Copy of This Authorization- I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
·Right to Refuse to Sign This Authorization- I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment or payment, on my decision to sign this authorization.
·Right to Withdraw This Authorization- I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Director of Health Information Management at (775) 204-0150.. I am aware that the revocation will not apply to information that has already been released in response to this authorization.
I have had an opportunity to review and understand the content of this authorization form.
By signing this authorization, I am confirming that it accurately reflects my wishes.

6. Signature of Patient: ____________________________________
Date: ____________________

(If signed by a person other than a patient, state relationship and authority to do so.)
Signature of Witness: ____
Relationship to Patient: ____
Date:_______________________

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