



Preferred Family Medicine
9120 Double Diamond Pkwy
Reno, NV 89521
Phone: (775) 204-0150 / Fax: 775-501-6360
PreferredFamilyMedicine.com

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

1. Name of Patient _____ Birth Date _____

Street Address _____ City, State, Zip _____

2. AUTHORIZES: Preferred Family Medicine

3. TO OBTAIN PROTECTED HEALTH INFORMATION FROM:

4. INFORMATION TO BE OBTAINED:

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

For the following dates:

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.

5. PURPOSE FOR NEED OF DISCLOSURE: (Check all that apply)

Further Medical Care Personal
 Insurance Eligibility/Benefits Changing Physicians
 Legal Investigation or Action Other (Specify):

6. 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.

7. 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.

8. Expiration Date: This authorization is good until the following date(s) N/A _____ or _____ event(s) (specify event) .

If I fail to specify an expiration date or event, this authorization will expire 90 days from the date on which it was signed.

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.

9. Signature of Patient: _____ Date: _____ (If signed by person other

than patient, state relationship and authority to do so.)

Patient is: Minor Incompetent Disabled Deceased

Legal Authority: Custodial Parent Legal Guardian Executor of Estate of Deceased Power of Attorney for Healthcare Authorized Legal Representative

Signature of Witness: _____ Date: _____