Authorization for Release of Protected Health Information (PHI)

Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Social Security No. *(optional)*:**	
Home Telephone Number:	**Recipient's Name:**		
Provider's/Health Plan's Address: Sunrise Hospital & Medical Center Medical Records Department 3186 South Maryland Parkway Las Vegas, NV 89109	**Address 1:**		
	Address 2:		
	City:	**State:**	**Zip:**

This authorization will expire on the following: (Fill in the Date or the Event but not both. If left blank, then this consent will automatically expire one year from the date signed. This consent may be revoked upon request at which time it will no longer serve any other future request. **Date:** **Event:**

THE UNDERSIGNED hereby authorizes and requests SUNRISE HOSPITAL & MEDICAL CENTER to provide records to the following:

☐ Physician; ☐ Hospital; ☐ Personal Use (.60/page); ☐ Insurance (.60/page); ☐ Attorney (.60/page)

☐ Other: _____

Description of information to be used or disclosed

Description:	**Date(s):**	**Description:**	**Date(s):**	**Description:**	**Date(s):**
☐ All PHI in medical record ☐ Dictation reports ☐ Physician orders ☐ Imaging/Radiology ☐ Laboratory reports ☐ Medication Sheets		☐ SCAN record ☐ Cardiac studies ☐ Progress notes ☐ Nursing notes ☐ Transfer forms ☐ ER Information		☐ Abstract: ☐ Other: ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, STDs or AIDS information. _____ (Initial) .

I understand that:

I may refuse to sign this authorization and that it is strictly voluntary.

My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.

If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

What is the purpose of this use or disclosure?

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	**Date:**
Print Name of Patient/Plan Member's Representative:	**Relationship to Patient/Plan Member:**