

AUTHORIZATION TO RELEASE RECORDS TO NEVADA PAIN

Patient Name: _____ **Date of Birth:** _____

I hereby authorize _____

Phone: _____ **Fax:** _____

or its agent(s) to disclose my health information as described in this authorization to:

Nevada Pain Specialists, (NP)

Office: 480-563-6400 Fax: 480-563-8009

Choose Practice Location:

Las Vegas: 7220 S. Cimarron Rd, Suite 270, Las Vegas, NV 89113

Henderson: 1681 W. Horizon Ridge Pkwy, Henderson, NV 89012

Health information to be disclosed: (check appropriate box)

2 years prior from last date seen by the healthcare provider

The following health information (be specific):

The health information is being disclosed for the following purpose: (check appropriate box):

Change of Insurance or Physician

Continuation of Care

- I understand I may revoke this Authorization at any time by sending written notice of my revocation to NP’s health information management department. I understand that my revocation will not be effective to the extent the healthcare provider has taken action in reliance on this Authorization. Unless revoked sooner, this Authorization will expire on the following date, event, or condition: . If no date, event, or condition is written, this authorization will expire 1 year from the date signed. A photocopy of this Authorization will expire 1 year from the date signed. A photocopy of this Authorization will be considered effective and valid as the original.
- I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.
- I understand that NP may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may re-disclose the records and that the records may no longer be protected by Federal privacy regulations.

I have read this Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions.

X _____

Signature of Patient / Parent / Guardian or Authorized Representative

Date

(Guardian or Authorized Representative must attach documentation of such status.)

Printed name of Authorized Representative and Telephone Number

Relationship / Capacity to