Premiere Surgical Specialists

6554 S. McCarran Blvd, Suite B, Reno, NV 89509

General, Vascular, Trauma, and Laparoscopic Surgery

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	**Date of Birth**	**Social Security Number**
Patient Address		**Phone Number**

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with Nevada State Statute and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization my include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV RELATED INFORMATION** only if I place my initials on the appropriate line in Item 10(a), I specifically authorize release of such information to the person(s) indicated in Item 9.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may not longer be protected by federal or state law.
6. I understand that in compliance with Nevada statute, I will pay a fee of $___________(.60/page) and postage. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.
7. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEATH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**
8. Name and address of health provider or entity to release this information:
9. Name and address of person(s) or category of person to whom this information will be sent:
10. (a) Specific information to be released:

☐ Medical Record from (insert date)_________________to (insert date)________________

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other:___________________________

____

Include: (Indicate by Initialing)

_______**Alcohol/Drug Treatment**

_______**Mental Health Information**

_______**HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _________I authorize ____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

____

(Attorney/Firm Name or Governmental Agency Name)

11. Reason for release of information: ☐ At request of individual ☐ Other:___________________________	12. Date or event on which this authorization will expire (90 days after I have signed the form):
13. If not the patient, name of person signing form:	14. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered.

____ ______________________________

Signature of patient or representative authorized by law. Date

FOR OFFICE USE ONLY

Date request filled:__________________________________ **By:**____

Identification presented:____________________________________ **Fee Collected: $**_________________________________