Dr. Bomer and Associates, LLC

7351 W. CHARLESTON BLVD., STE 140, LAS VEGAS, NV 89117
TELEPHONE: 702 476-3140 FAX: 702 476-3141
Email: admin@drbomerandassociates.com

RELEASE OF INFORMATION

Name:_____ Medicaid #_____ D.O.B._____

INFORMATION TO BE RELEASED FROM:

Name/Agency_____

Address:_____

INFORMATION TO BE RELEASED TO:

Name/Agency: _____

Address: _____

PURPOSE OF RELEASE:

_____

_____Written Disclosure _____Verbal Disclosure
(Initial one or both disclosure types)

_____ _____
Requesting Individual's Name Requesting Individual's Signature

INFORMAITON TO BE RELEASED: (Individual must initial each item of information to release)

_____Consultation Reports	_____History& physical exam	_____Treatment plan
_____ Diagnosis (psychiatrist)	_____HIV/AIDS info.	_____Psychiatric evaluation
_____Discharge summary	_____Medication Records	
_____Drug & Alcohol abuse info	_____Progress Notes	
_____General Summary Letter Only	_____Psychological assessment	

_____Other (specify)_____

INFORMATION FOR INFORMED CONSENT

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including Nevada Revised Statutes and Title 42 of the Code of Federal Regulation. These Statutes, Rules and Regulations require that the individual give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations.

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Consent to release information will be considered valid only when it states: (1) who will release the information; (2) who will receive the information; (3) the purpose for which the information will be used; (4) what specific information will be released; and (5) when the consent will expire. The consent must contain the individual's or authorized representative's signature and the date of the signature. The authorized representative signing for the client must submit a copy of the legal document(s) granting this authority.

This authorization for the release of Medical information waives any and all rights that the individual now has or in the future may have to bring any legal action against the releasing person/facility for any damages caused directly or indirectly by the release of this information or other confidential information. Upon request, the individual will be given a copy of the completed" Authorization for the Release of Client Information".

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. This authorization expires _____days from the date of signing, or in 365 days (or upon case closure), whichever comes first.

DATE: _____ DATE: _____

_____ _____
Signature of parent/guardian/representative Signature of Client

_____ _____
Relationship to Client Signature of Witness