WHASN
Women's Health Associates of Southern Nevada

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name	Date of Birth	Medical Record Number
Patient Address	**City**	**State/Zip Code**

I, or my authorized representative, request that health information regarding my health care and treatment as forth on this form:

In accordance with Nevada State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, **GENETIC TESTING, AND CONFIDENTIAL HIV RELATED INFORMATION** only if I place my initials on the appropriate line in item 6(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in item 6(a), I specifically authorize release of such information to the person(s) indicated in item 6(d).

2. If I am authorizing the release of alcohol, drug abuse treatment, mental health treatment, genetic testing, or HIV-related information, the recipient is prohibited from re-disclosing 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 my authorization. If I experience discrimination because of the release of disclosure of HIV-related information or believe my personal health information has been disclosed without my consent, I may contact the Nevada Attorney General at 775-684-1108 or the Regional Office for Civil Rights Region IX at 800-368-1019. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing 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. I further understand that if I am authorizing the release of my health information to the care provider listed below to seek payment for health care provided to me, I cannot revoke the authorization to the extent that the records are needed to secure payment for these services.

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 re-disclosed by the recipient (except as noted above in item 2), and this re-disclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY, GOVERNMENTAL AGENCY, PROVIDER, PERSON OR ENTITY SPECIFIED IN ITEM 6(B).**

6(a) Specific information to be released:

- ☐ Medical records (office notes, radiology studies, lab results) from: _____/_____/_____ to _____/_____/_____
- ☐ Medical records (office notes, radiology studies, lab results) for the past year only.
- ☐ Last 4 pap smear ☐ Last 4 mammogram ☐ Last 4 DEXA scan
- ☐ Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other healthcare providers.
- ☐ Sensitive records requested: (Indicate by Initialing) _____ **Alcohol/Drug Treatment** _____ **Mental Health Information** _____ **HIV-Related Information** _____ **Genetic Information**

Authorization to Discuss Health Information

6(b) By initialing here_____ I authorize _____ to discuss my health information with my attorney, governmental agency, other care provider(s) or person(s) listed below:

_____

6(c) Authorizing release of records from (provider/facility): _____

6(d) Release records to: _____
Name of Health Care Provider/Insurance/Other

6(e) Address to mail records: _____ Fax records to: _____

7. Reason for release of information: ☐ Transferring Medical Care ☐ Primary Care Provider ☐ Consulting Provider ☐ Personal Records ☐ Insurance Eligibility/Benefits ☐ Moving Out of State ☐ Legal Investigation ☐ Other_____

8. If not the patient, name of person signing form:	9. Authority to sign on behalf of patient:

10. Expiration date of authorization: _____/_____/_____ Expiration event of authorization: _____
(If no expiration date or event is selected, authorization will expire in one (1) year)

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form. I further understand that there may be a copy fee of 0.60 cents per page.

_____ _____/_____/_____

Signature of patient or representative authorized by law Date