Valley Health
PHYSICIAN ALLIANCE

Las Vegas
Cardiovascular
Surgery Specialists

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____
Maiden/Prior Names: _____ Current Phone #: ____-____-____
Current Address: _____

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination
☐ Legal Investigation ☐ Other: _____

I authorize the release of the following:

☐ Provider office note
☐ Lab results
☐ Diagnostic Reports
☐ Other: _____

Items below will not be included unless checked:

☐ Psychological Evaluation
☐ Alcohol and Drug Abuse Treatment Records
☐ HIV Test Results and AIDS Treatment Records

Obtain my health information from:

☐ _____ (____)____-____-____ _____
Facility/Provider's Name **Telephone or Fax Number** **Address** **City** **State** **Zip Code**

Release my health information to:

☐ _____ (____)____-____-____ _____
Facility/Provider's Name **Telephone or Fax Number** **Address** **City** **State** **Zip Code**

This authorization will expire on ____/___/20____. (If not indicated, authorization will expire one year from signature date)

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

This form must be completed in full before signing:

_____ _____ _____
Patient's signature (required for ages 12 and older) **Parent/Legal Guardian signature (if applicable)** **Relationship to patient**

_____ _____
Witness signature **Date Signed**

This authorization is intended to allow The Pavilion to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPPA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and all federal regulations and interpretive guidlines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) or the STAE MENTAL HEALTH ACT is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. FACILITY is not liable for such re-disclosures.