

# Authorization for Release of Protected Health Information (PHI)

Section A: This section must be completed for all Authorizations			
Patient Name:	Birth Date:	Social Security No. (optional):	
Home Telephone Number:	Recipient's Name: (Include recipient and physician's name for radiology films)		
Provider's Name and Address:  Mountain View Hospital 3100 N. Tenaya Way Las Vegas, Nevada 89128 (702) 255-5048 Medical Records Dept (702) 255-5080 Radiology/Fax 562-5512	Address 1:		
	Address 2:		
	City:	State:	Zip:
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: _____ Event: _____			
What is the purpose of this use or disclosure? <input type="checkbox"/> Physician; <input type="checkbox"/> Hospital; <input type="checkbox"/> Personal Use (.60/page); <input type="checkbox"/> Insurance (.60/page); <input type="checkbox"/> Attorney (.60/page); <input type="checkbox"/> Other: _____			
<input type="checkbox"/> Radiology X-ray Disk (Personal/Attorney \$15.00/disk); <input type="checkbox"/> Personal Radiology Actual Films (Personal/Attorney \$15.00/sheet)			
<del>Description of information to be used or disclosed; (ANY AND ALL DATES OF SERVICE WILL NOT BE ACCEPTED)</del>			
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.			
Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Abstract (Pertinent) <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Medication sheets <input type="checkbox"/> EKG's & EEG Reports <input type="checkbox"/> Radiology reports <input type="checkbox"/> Cardiac studies		<input type="checkbox"/> Progress notes <input type="checkbox"/> Nursing notes <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information <input type="checkbox"/> Operative information <input type="checkbox"/> Rhythm strips <input type="checkbox"/> Itemized bill <input type="checkbox"/> Other	Imaging/Radiology Disk/Films <input type="checkbox"/> CT's <input type="checkbox"/> Mammograms <input type="checkbox"/> MRI's <input type="checkbox"/> Nuc Med <input type="checkbox"/> Special Procedures (Angios) <input type="checkbox"/> Ultrasound; <input type="checkbox"/> X-Ray's
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, STDs, genetic testing, or AIDS information (Initial). If not applicable, check here (Initial).			
I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it.			
Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.			
Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? If yes, describe: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
Section C: Signatures			
I have read the above and authorize the disclosure of the protected health information as stated.			
Signature of Patient/Patient's Representative:			Date:
Print Name of Patient/Patient's Representative:			Relationship to Patient: