

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:				
Provider's / Health Plan's Address: Sunrise Hospital & Medical Center Medical Records Department 3186 South Maryland Parkway Las Vegas, NV 89109	Address 1:		Address 2:		
	City:		State:	Zip:	
	This authorization will expire on the following: Date: _____ Event: _____ (Fill in the Date or the Event but NOT both.) If left blank, then this consent will automatically expire one year from the date signed. This consent may be revoked upon request at which time it will no longer serve any other future request.				
THE UNDERSIGNED hereby authorizes and requests SUNRISE HOSPITAL & MEDICAL CENTER to provide records to the following: <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: _____					
Description of information to be used or disclosed ("ANY" AND " ALL " in substitution for DATES OF SERVICE WILL NOT BE ACCEPTED)					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Imaging / Radiology <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Medication Sheets <input type="checkbox"/> EKG's & EEG Reports		<input type="checkbox"/> SCAN record* <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"/> Angiogram's		<input type="checkbox"/> CT's <input type="checkbox"/> Mammograms <input type="checkbox"/> MRI's: <input type="checkbox"/> Nuc Med <input type="checkbox"/> PET Scan's <input type="checkbox"/> US: <input type="checkbox"/> X-Rays	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, STD's, Genetic testing, or AIDS information. _____ (Initial). *All other abuse related information _____. (Initial).					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. 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. 4. 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. 5. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____					
What is the purpose of this use or disclosure? _____					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient / Plan Member / Guardian / Patient / Plan Member Representative:				Date:	
Print Name of Patient / Plan Member's Representative:				Relationship to Patient / Plan Member :	

00172-SZ 04/30/08

PLEASE NOTE WHO YOU ARE GIVING PERMISSION TO PICK UP YOUR FILMS _____
(THEY NEED YOUR FEDERAL ID AND A FEDERAL ID FOR THEMSELVES: DRIVERS LICENSE, SOCIAL SECURITY CARD.)