HENDERSON OB/GYN

129 W. Lake Mead Hwy. Ste. 19 ✡ Henderson, NV 89015
Phone: (702) 568-6108 ✡ Fax: (702) 568-8603

Authorization to Disclose Protected Health Information

Patient Name: ____________________ SS#: ____________ DOB: __________

Address: ____________________ City: __________ State: ______ Zip: ________

1. **I authorize the use or disclosure of the above named individual's Protected Health Information as described below.**
2. **The following individual or organization is authorized to make the disclosure:**

   Name: ____

   Address: ____________________ City: ____________ State: ______ Zip: ______

   Phone Number: (_____)______________ Fax Number: (____)__________________

3. **The type of information to be used or disclosed is as follows: (include dates where appropriate)**

   Obstetrical Records   Gynecologic Records   Entire Record

   Laboratory Results from (date) __________ to (date) __________ Name of Lab Test: __________

   X-Ray and Diagnostic Report from (date) ____________ Type of Study ____________________

   Other ____

   ____

4. **REASON FOR REQUEST: (PLEASE CHECK ONE)**

   Medical Care   **Insurance**   **Personal**   **Attorney**

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my revocation to Henderson OB/GYN. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ________________________. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. The information will be disclosed to and used by the following individual or organization: ____________________

   ____

   Address   City. State. Zip   Phone Number   Fax Number

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redsiclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient: ________________________________ Date: __________________

Signature of Parent, Guardian
Or Personal Representative (if necessary): ________________________ Date: __________________

THERE WILL BE A CHARGE OF $1.00 PER PAGE AND A $16.00 ADMINISTRATIVE FEE WHEN RELEASING RECORDS DIRECTLY TO THE PATIENT.
PLEASE ALLOW 3-5 DAYS FOR PROCESSING