

Kidney Specialists of Southern Nevada

Legal entity name: Nephrology & Endocrine Associates

AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

DATE	HEALTH RECORD NUMBER	PATIENT'S DOB
------	----------------------	---------------

PATIENT'S NAME (Last)	(First)	(M.I.)
-----------------------	---------	--------

I, _____, authorize the use or disclosure of the above named individual's health information described below. The following individuals or organizations have authorization to make disclosure of my health information records:

ORGANIZATION'S NAME		
ADDRESS		
CITY	STATE	ZIP

RELEASE INFORMATION TO	
ORGANIZATION'S NAME	
ADDRESS	
PHONE NUMBER	FAX NUMBER

DATE RANGE OF RECORDS TO BE RELEASED: From: _____, 20____ to: _____, 20____

I WOULD LIKE A COPY OF MY RECORDS ON Paper @ .60s per page CD

- | | | |
|---|---|--|
| <input type="checkbox"/> Entire Health Records | <input type="checkbox"/> Biopsy Results | <input type="checkbox"/> Blood Sugar Values |
| <input type="checkbox"/> Cancer Log | <input type="checkbox"/> Correspondence | <input type="checkbox"/> EKG |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Hospital Records | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Prescription List | <input type="checkbox"/> Outside Records | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Transplant Information | <input type="checkbox"/> X-Ray Results | <input type="checkbox"/> Financial Information |

This authorization to release health information expires on: _____, 20____. If no date is provided the Authorization will expire one year from the signature date. I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and the treatment for alcohol and drug abuse. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information privacy officer. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when it provides my insurer with the right to consent a claim under my insurance policy unless otherwise revoked. **This authorization will expire on the following date or condition: _____, 20____. If I fail to specify an expiration date, event or condition this authorization will expire one year from the signature date below.** If I have any questions regarding this disclosure of my health information I can contact the privacy officer at 702-877-1887.

Patient Signature or Legal Representative _____ Date _____ 20____

If Signed by Legal Representative, Relationship to Patient _____ Date _____ 20____

Central Office: 500 S. Rancho Drive, Ste. 12 • Las Vegas, Nevada 89105 • 702-877-1887 • Fax 702-877-4836
 Northwest Office: 653 Town Center Drive Bldg. 2, Ste. 70 • Las Vegas, Nevada 89144 • 702-877-1887 • Fax 702-315-8530
 Southwest Office: 6280 W. Sunset Rd., Ste. 306 • Las Vegas, Nevada 89148 • 702-877-1887 • Fax 702-262-0514