Community Outreach
MEDICAL CENTER
BRINGING COMMUNITY AND HEALTHCARE TOGETHER

Patient Authorization
Release of Medical Records

Patient Name: ______________________________ DOB: ______________ Date: ______________

Address: ____ Apt/Unit: ____________

City: ______________________________ State: ______________ Zip Code: ____________

I hereby authorize the release of my medical records as follows:

(Please select the appropriate box)

☐ TO ☐ FROM

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone: ______________ Fax: ______________

☐ TO ☐ FROM

Community Outreach Medical Center (COMC)

1090 E. Desert Inn, Suite 200

Las Vegas, NV 89109

P: (702) 657-3873/F: (702) 636-0787

Patient information is needed for the following purpose(s):

☐ Medical Care ☐ Personal ☐Insurance ☐Legal ☐Military ☐Other ______________

I give authorization to disclose or release the following medical records: (Note: there is a $0.60 per page photocopy fee)

☐ Complete medical record
☐ Medical history, evaluation records
☐ Consultation documentation
☐ Physician orders
☐ Photographs
☐ Billing records
☐ X-Ray reports
☐ Laboratory & Radiology reports
☐ Immunization records
☐ Prescription/medication data
☐ Surgical reports
☐ Other records (please specify): ______________________________

Medical records contain health information, treatment and/or condition. Health information may include and is not limited to information regarding communicable diseases, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), alcohol and drug use, behavioral health or mental health treatment.

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

I understand that I may evoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. I will notify the person(s) and/or agency listed above either by verbal or written revocation.

I understand that this authorization will expire 90 days from the day of my signature, unless I revoke the authorization prior to the expiration date.

____

Patient Signature or Legal Representative *Date*

If Legal Representative, please list relationship to patient: ______________________________