Community Outreach
MEDICAL CENTER
BRINGING COMMUNITY AND HEALTHCARE TOGETHER

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip Code: _____

I hereby authorize (Name of provider releasing records):

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

To release to (Required Information):

Name: **Community Outreach Medical Center**

Address: **1090 E. Desert Inn Rd. Suite #200**

City, State, Zip: **Las Vegas, Nevada 89109**

Phone: **(702) 657-3873** Fax: **(702) 636-0787**

The purpose for this information requested is: (Note: There is a $0.60 per page photocopy fee)

_____ Healthcare Provider _____ Personal _____ Attorney ____ Insurance _____ Other _____

Dates of services requested: _____

The purpose of this disclosure is: _____

The following information is requested:

_____ PHI Pertinent for continuing healthcare or personal health records, Includes: Social Summary, H&P, Consults, Lab & Radiology Reports, EKG, Diagnostic Test Reports, Discharge Instructions	_____ Anesthesia Records _____ Billing Records _____ Consent Forms _____ Immunization Records _____Medication Records	_____ Nurse Notes _____ Photographs _____ Physician Notes _____ Physician Orders _____ Physician Progress Notes _____Other records, specify:_____

_____ (Patient Initials) I acknowledge and hereby consent that the release of information may also contain the following Protected Health Information:

Definition: Sexually Transmitted Diseases (STD) as defined by law RCW 70.24 et seq., include Herpes, Herpes Simplex, Human Papilloma Virus, Wart, Genital Wart, Condyloma, Non-specific Urethritis, Syphilis, Chancroid, Lymphogranuloma Venereum, HIV (Human Immunodeficiency Virus) AIDS (Acquired Immune Deficiency Syndrome), Chlamydia, Gonorrhea.

_____ (Patient initials) I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive to the person(s)/agency listed above. I understand that the person(s)/agency listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

_____ (Patient initials) I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s)/agency listed above.

Re-disclosure of Information: : I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and accountability Act of 1996 (HIPPA), protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure.
Right to revoke this Authorization: I understand that I my revoke this authorization I writing at any time except to the extent that action has been taken in reliance on it. To revoke this authorization, I will notify the person(s)/agency listed above either by verbal or written revocation.
Expiration Date: I understand that unless I provide a written revocation at an earlier date, this authorization will expire 90 days from the original signature date.

Patient/Legal Representative Signature: _____ Date: _____

Relationship to Patient: _____ Witness signature: _____