Patient Name: ____ Date of Birth: ___________________________________

Address: ____ City: _________________ State: _____ Zip: __________________

I hereby authorize (Name of provider/agency releasing records): To release to (Required Information) :

Name: **Community Outreach Medical Center**	Name: ____
Address: **1140 Almond Tree Lane, Suite 306**	Address: ____
City, State, Zip: **Las Vegas, NV 89104**	City, State, Zip: ____
Phone: **702-657-3873** Fax: **702-636-0787**	Phone: __________________ Fax:_______________________

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

_______ Healthcare Provider _______Personal Use ________Attorney ________Insurance

Dates of services requested: ____

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	___Nurses Notes ___Photographs ___Physicians Notes ___Physician's Orders ___Physician Progress Notes

_______ (Pt.Initials) Other, specify: ____

I acknowledge and hereby consent that the released 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, Chlamydia, non-specific urethritis, syphilis, chancroid, lymphogranuloma, venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

_______ (Pt. 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.

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

The purpose of this disclosure is: ____

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 (HIPAA), 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 may revoke this authorization in 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 a verbal or written revocation.
Expiration Date: I understand that unless I provide a written revocation at an earlier date, this authorization will expire in 90 days from the original signature date.

Patient Signature:____Date:____________________________
Relationship to Patient:____________________________________Witness:___________________________