COMMUNITY OUTREACH MEDICAL CENTER
Bringing Community and Healthcare Together in Southern Nevada

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Name: _____ Name: **Community Outreach Medical Center**

Address: _____ Address: **1140 Almond Tree Lane, Suite 306**

City, State, Zip: _____ City, State, Zip: **Las Vegas, NV 89104**

Phone: _____ Fax: _____ Phone: **702-657-3873** Fax: **702-636-0787**

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:_____