AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth
Address	

I, or my authorized representative(s), request that health information regarding my child's care and treatment as set forth on this form:

In accordance with Nevada State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment, except psychotherapy notes, and confidential HIV related information only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated on Item 8.
2. I have the right to revoke this authorization at any time by writing to A Las Vegas Medical Group. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3. I understand that signing this authorization is voluntary. My child's treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
4. Information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law.
5. **THIS AUTHORIZATION DOES NOT AUTHORIZE A LAS VEGAS MEDICAL GROUP TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE INDIVIDUALS/AGENCIES SPECIFIED BELOW:**

Name and address of health provider or entity to release this information: **A LAS VEGAS MEDICAL GROUP**	
Names of Individuals/Agencies authorized to receive my OR my child's Protected Health Information (PHI):	
Specific information to be released: ☐ Medical Record from (insert date) _____ to (insert date) _____ ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to A Las Vegas Medical Group by other health care providers. □ Other _____	
Reason for release of information: □ At request of patient OR Parent/Guardian □ Other: _____	Date or event on which this authorization will expire
Printed name Patient OR Parent/Guardian	Relationship to patient

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date _____

Signature of Patient OR Parent/Guardian

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