Phillips Clinic
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5970C S. Rainbow Blvd. #100
Las Vegas, Nevada 89118
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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____SSN_____
Address:_____
City_____ State _____ Zip _____ Date of Birth _____

I AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUAL'S PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW.

The following individual or organization is authorized to make the disclosure:
Name_____
Address_____

The type and amount of information to be used or disclosed is as follows:
____Progress Notes _____Medication list _____Immunization Record
____Lab Results_____Xray and Diagnostic Reports _____Entire Record
____Other

I GIVE PERMISSION TO RELEASE ANY INFORMATION REGARDING:
_____Substance Abuse _____Psychiatric/Mental Health _____ HIV

Reason for request
____Medical Care ____Insurance ____Personal ____Attorney____Other

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in wring and present my written revocation to the office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. If I fail to specify an expiration date, event or condition, the authorization will expire in six months.

The information will be disclose to and used by the following individual or organization:_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this for in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office and obtain a copy of the Privacy Notice.

Signature of Patient_____ Date _____

Signature of Parent, Guardian, or personal representative_____
Date:_____