



SOUTHWEST MEDICAL ASSOCIATES®  
 PO Box 15645 \* Las Vegas, NV 89114-5645 \* Fax: (702) 877-8310  
**Authorization to Disclose Protected Health Information (PHI)**

**This request to RELEASE medical records will be returned if not completed in its entirety**

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ DOB \_\_\_\_\_

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

① The type and amount of information to be used or disclosed is as follows

Include dates where appropriate: FROM (date) \_\_\_\_\_ THROUGH (date) \_\_\_\_\_

- Entire Record, or:
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Medication List    | <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Provider Notes     |
| <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> X-Ray/Dexa Reports   | <input type="checkbox"/> Cardiology Reports |
| <input type="checkbox"/> Other _____        |   |   |

② Please initial for release of the following information even if you checked "Entire Record" above.

_____ Substance Abuse	_____ Psychiatric / Mental Health Information	_____ HIV Information
_____ Genetic Test Results	_____ Child & Domestic Abuse History	_____ Addictive Behavior
_____ Communicable and Sexually Transmitted Disease		

③ REASON FOR REQUEST: (PLEASE CHECK ONE)

- Medical Care  Insurance  Personal  Attorney  Other \_\_\_\_\_

④ I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_ IF LEFT BLANK, THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS

⑤ THIS INFORMATION IS TO BE DISCLOSED TO  Requestor  the following individual or organization

Name	Phone number	Fax number
Address	City, State, Zip	

⑥ I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form 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 Health Information Management Department and obtain a copy of the Privacy Notice.

⑦ I wish to receive this information on  Paper  CD (as a PDF file)

Signature of Patient: \_\_\_\_\_  
Date of Signature

Signature of Parent, Guardian  
 or Personal Representative  
 (if necessary): \_\_\_\_\_  
 (If Personal Representative, attach supporting documentation) Date of Signature

Routed to: _____
By: _____
Date: _____
Completed: ____Y ____N
Scanned by: (initial) _____
Photo ID checked by: _____

**NOTE: There is a charge of 60 cents per page unless information is being disclosed to a medical facility.  
 PLEASE ALLOW 7-10 BUSINESS DAYS from date of receipt by HIM Dept FOR PROCESSING. Phone: (702) 877-8636 M-F, 8am-5pm**