



\* R O I R C D \*

PLACE PATIENT LABEL TO COVER OR COMPLETE BELOW:

Patient Name: \_\_\_\_\_
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_
Account #: \_\_\_\_\_
Med Rec #: \_\_\_\_\_

PROTECTED HEALTH INFORMATION (PHI)
RELEASE AUTHORIZATION

MRU00695 (09/07/18)

Page 1 of 1

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS # (optional): \_\_\_\_\_
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Phone #: \_\_\_\_\_ Alt. #: \_\_\_\_\_ Email Address: \_\_\_\_\_

I authorize the following facility(ies) to release my Protected Health Information (PHI) for the specified dates of service:

- University Medical Center of Southern Nevada main hospital campus (UMC) -> Dates of Service: \_\_\_\_\_
UMC Quick Care+ (specify locations): \_\_\_\_\_ -> Dates of Service: \_\_\_\_\_
UMC Primary Care+ (specify locations): \_\_\_\_\_ -> Dates of Service: \_\_\_\_\_

I authorize the following PHI to be released from my medical record (check all that apply):

- Abstracts/Summaries (includes: Discharge Summary, History and Physical, Operative Reports, Consultations and Test Results)
Emergency Room Record Radiology Reports Radiologic film / digital imaging
Test Results of (specify): \_\_\_\_\_ Other (specify): \_\_\_\_\_

The information in my health record may include information relating to sexually transmitted disease, mental health services, and treatment of alcohol or drug abuse. State and federal law protect the following information. If this information applies to you, please indicate if you would like this information to be released / obtained, include dates of service where appropriate and then initial each line:

- Alcohol, Drug, or Substance Abuse Yes No -> Dates of Service: \_\_\_\_\_ Initials: \_\_\_\_\_
HIV Testing and Results Yes No -> Dates of Service: \_\_\_\_\_ Initials: \_\_\_\_\_
Mental Health Records Yes No -> Dates of Service: \_\_\_\_\_ Initials: \_\_\_\_\_
Psychotherapy Records Yes No -> Dates of Service: \_\_\_\_\_ Initials: \_\_\_\_\_
Genetic Records Yes No -> Dates of Service: \_\_\_\_\_ Initials: \_\_\_\_\_

I request that my PHI be disclosed to the following person: Patient (self) Other recipient (complete below)

Recipient's Name (ONE per request): \_\_\_\_\_ Phone #: \_\_\_\_\_
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Email Address (optional): \_\_\_\_\_ Fax #: \_\_\_\_\_

Purpose for requesting the release of my PHI (select one): Legal Insurance Personal Continuation of Care

Other purpose (specify): \_\_\_\_\_

Disclosure Format: Paper (default if none selected) CD-ROM / disc Other / Special Request: \_\_\_\_\_

Disclosure Method: Call for pick-up Send via US Mail Send via Fax Other / Special Request: \_\_\_\_\_

This authorization will expire one year from the date of signature (default) or on the following date / event / condition:

Date / Event / Condition (specify): \_\_\_\_\_

By signing this authorization form, I understand that:

- 1. Requests for copies of medical records are subject to reproduction fees in accordance with federal / state regulations.
2. Authorizing this release of information is voluntary and I may refuse to sign this document.
3. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
4. I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the UMC Health Information Management Department at the following address: 1800 W. Charleston Blvd., Las Vegas, Nevada 89102. Revocation will not apply to information that has already been disclosed in response to this authorization.
5. The information disclosed pursuant to this authorization may be subject to re-disclosure and therefore no longer protected by federal privacy regulations.

Time: \_\_\_\_\_ Date: \_\_\_\_\_ Patient or Patient Representative's\* Signature: \_\_\_\_\_

Patient Representative's Name (if applicable): \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

\*(Note: Guardians and Durable Power of Attorney designees should include a copy of the applicable paperwork with this request.)

**UMC QUICK CARES:**

- **Blue Diamond Quick Care**  
4760 Blue Diamond Road, #110  
Las Vegas, NV 89139
- **Centennial Hills Quick Care**  
5785 Centennial Center Boulevard  
Las Vegas, NV 89149
- **Enterprise Quick Care**  
1700 Wheeler Peak Street  
Las Vegas, NV 89106
- **Nellis Quick Care**  
61 N. Nellis Boulevard  
Las Vegas, NV 89110
- **Peccole Quick Care**  
9320 W. Sahara Avenue  
Las Vegas, NV 89117
- **Rancho Quick Care**  
4231 N. Rancho Drive  
Las Vegas, NV 89130
- **Spring Valley Quick Care**  
4180 S. Rainbow Blvd, # 810  
Las Vegas, NV 89103
- **Summerlin Quick Care**  
2031 N. Buffalo Drive  
Las Vegas, NV 89128
- **Sunset Quick Care**  
525 Marks Street  
Henderson, NV 89014

**UMC PRIMARY CARES:**

- **Nellis Primary Care**  
63 N. Nellis Boulevard  
Las Vegas, NV 89110
- **Peccole Primary Care**  
9320 W. Sahara Avenue  
Las Vegas, NV 89117
- **Rancho Primary Care**  
4233 N. Rancho Drive  
Las Vegas, NV 89130
- **Southern Highlands Primary Care**  
11860 Southern Highlands Parkway, #102  
Las Vegas, NV 89141
- **Spring Valley Primary Care**  
4180 S. Rainbow Blvd, # 810  
Las Vegas, NV 89103
- **Summerlin Primary Care**  
2031 N. Buffalo Drive  
Las Vegas, NV 89128
- **Sunset Primary Care**  
525 Marks Street  
Henderson, NV 89014
- **Wellness Center**  
701 Shadow Lane, # 200  
Las Vegas, NV 89106