UNIVERSITY MEDICAL CENTER

ROIRCD

PLACE PATIENT LABEL TO COVER OR COMPLETE BELOW:

Patient Name:_____

DOB:_____ Age:_____ Sex:_____

Account #:_____

Med Rec #:_____

PROTECTED HEALTH INFORMATION (PHI) RELEASE AUTHORIZATION

MRU00695 (06/06/16)

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 Legal Representative's* Signature:**_____

Legal 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.)*

ORIGINAL: Medical or Billing Record COPY: Patient or Patient's Legal Representative †See reverse for a list of locations

UMC QUICK CARES:

- **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, Suite 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:

- **Wellness Center**
  701 Shadow Lane, Suite 200
  Las Vegas, NV 89106

- **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

- **Spring Valley Primary Care**
  4180 S. Rainbow Blvd, Suite 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