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)*: RECORDS DEPOSITION SERVICE, INC. Phone #: 248-357-3330

Street Address: PO BOX 5054 City: SOUTHFIELD State: MI Zip Code: 48086-5054

Email Address *(optional)*: REQUESTS@RECDEP.COM Fax #: 248-357-3337

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.)*