HENDERSON WELLNESS CLINIC

1490 W Sunset Road, Suite 120 * Henderson, NV 89014 *** Fax: (844) 389-0835**

Authorization to Disclose Protected Health Information (PHI)

This request to OBTAIN medical records will be returned if not completed in its entirety.

Patient Name: _____ Medical Record Number: _____

Address: _____ City: _____ State: _____ Zip: _____ DOB _____

① I HEREBY AUTHORIZE _____

		Phone Number
Address	City, State, Zip	Fax Number

TO DISCLOSE THE ABOVE NAMED INDIVIDUAL'S PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW:

② 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:

☐ Medication List ☐ Immunization Record ☐ Provider Notes

☐ Laboratory Results ☐ X-Ray/Dexa Reports ☐ Cardiology Reports

☐ Other _____

③ IF PRESENT, I GIVE PERMISSION TO RELEASE ANY SENSITIVE INFORMATION REGARDING: (Initial on Applicable Lines Below)

_____ **Substance Abuse** _____ **Psychiatric / Mental Health Information** _____ **HIV Information**

_____ **Genetic Test Results** _____ **Child & Domestic Abuse History** _____ **Addictive Behavior**

_____ **Communicable and Sexually Transmitted Disease**

④ REASON FOR REQUEST: Continuing Medical Care

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.

THIS INFORMATION IS TO BE DISCLOSED TO:

Henderson Wellness Clinic
1490 W Sunset Rd, Suite 120
Henderson, NV 89014

Phone No. (855) 955-5428 ext. 809
Fax No. (844) 389-0835

IF STAT, PLEASE FAX TO

Fax: _____

Please Notify (Clinical Director) upon receipt: _____

Signature of Patient: SIGN HERE _____

Date of Signature

Signature of Parent, Guardian or Personal Representative (if necessary): _____

(If Personal Representative, attach supporting documentation) *Date of Signature*

⑤ 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 I FAIL TO SPECIFY AN EXPIRATION DATE, EVENT OR CONDITION, THIS AUTHORIZATION WILL EXPIRE SIX MONTHS FROM THE DATE OF THIS AUTHORIZATION.

PLEASE NOTE:

- Requesting records on behalf of our patients for continuing medical care is done as a courtesy. We do not pay for records requested from previous providers. If payment is required, please obtain directly from the patient.
- If possible, please send requested records on CD, preferably in Adobe Acrobat format.