



Sierra Nevada Cardiology Associates

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Authorization for Disclosure of Patient Health Information

Section 1:

Patient's Name: Last: _____ First: _____
(please print)
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security Number: _____ Phone Number: _____

Section 2:

Authorizes Release of Protected Health Information

From: _____ To: _____
Name of Health Care Provider/Plan/Other Name of Health Care Provider/Plan/Other
Street Address Street Address
City, State, Zip Code City, State, Zip Code

Section 3: Information to be released:

- Medical History, Physical Exam, Reports
- Treatment or Tests
- Other (specify): _____
- OP Reports
- Laboratory Reports
- Consultation Reports
- X-Ray Reports

The information to be disclosed in the appropriate time frame of: ____/____/____ to ____/____/____

Section 4: Purpose or Need For Disclosure: (check all appropriate boxes)

- Further Medical Care
- Changing Physicians
- Other (specify): _____
- Insurance
- Personal Use
- Legal

Section 5: Expiration of Authorization:

- 1) This authorization is valid until calendar date: (Mo./Day/Yr.) _____.
- 2) Unless an earlier date is specified, this authorization will expire 12 months from the date of signature below.

Section 6: Signature:

I understand the following:

- 1) If the person or entity receiving this information is not a healthcare provider, health plan, or healthcare clearing house, which must follow the Federal Privacy Standards, the health information disclosed may no longer be protected by the federal privacy regulations and may be re-disclosed without my authorization.
- 2) I may review and copy the information disclosed.
- 3) Payment of a claim, enrollment, or eligibility for benefits will not be affected if I do not sign this form unless the disclosure of this information is required to determine payment, eligibility, enrolment, or for disability re-determination.
- 4) I may revoke this authorization at any time. The revocation must be in writing and must be sent/given to the records department named above in section 2. This revocation will not affect action already taken before the revocation is received.

Signature of Individual

Date

Signature of Representative

Date

***Authority to represent individual:** Parent Guardian Power of Attorney Authorized Representative

The charges for copying your medical records are: \$.60 per page, plus actual postage if mailed.