1231 Country Club Drive
Carson City, NV 89703

The Nevada Center

(775) 884-3990
Fax (775) 884-2202

Authorization to Release Health Information

I Hereby Authorize:

☐ The Nevada Center
☐ Facility/Physician: _____

Phone: _____ Fax: _____

To Release:

☐ Complete Health Record ☐ Laboratory Reports ☐ Imaging/Radiology
☐ Other: _____

From the Medical Records of Patient:

Name: _____ Date of Birth: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip Code: _____

To Be Released To:

☐ The Nevada Center
1231 Country Club Drive
Carson City, NV 89703
Phone: (775)884-3990
Fax: (775)884-2202

☐ Facility/Physician: _____

Phone: _____ Fax: _____

For the Purpose of:

☐ Insurance ☐ Concurrent Care ☐ Personal Use ☐ Legal ☐ Other: _____

I understand that unless revoked, this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document. I understand that my health care information is protected by State and Federal regulations that protect the confidentiality of this information and that my health care information may not be released or disclosed without my written authorization, unless otherwise provided by law. I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing.

_____

Signature of Patient/Parent/Legal Guardian Date