Premiere Surgical Specialists

Phone (775)324-0288 FAX (775)323-5504

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA (updated 12/22/2017)

Patient Name: _____ Birth date: _____
(Printed) (First) (MI) (Last) (mm/dd/ccyy)

Patient Address: _____ Phone: _____
(street address) (city) (state) (ZIP code)

I authorize Premiere Surgical Specialists, 6554 South McCarran Blvd, Suite B, Reno, NV 89509 to use and/or disclose my health and medical information, as specifically described below:

Release information to: _____ Relation to patient: _____ Phone: _____
(Full name or entity name)

Address: _____
(street address) (city) (state) (ZIP code)

Purpose of Request to Release:

- ☐ Treatment
- ☐ Payment/Insurance
- ☐ Personal
- ☐ Legal/Attorney
- ☐ Other (specify)_____

Information to be Released:

- ☐ Operative Report
- ☐ Billing Records
- ☐ Entire Medical Record
- ☐ Pathology Report
- ☐ Office Notes
- ☐ Other _____ (Specify)

For Date(s) of Service from: _____ to _____ **(Dates MUST be specified)**

I Specifically Authorize Release of These Records (records will not be released unless you check the box and initial)

- ☐ Release Substance Abuse Records Initials: _____
- ☐ Release Genetic Testing Information Initials: _____
- ☐ Release Mental Health Information Initials: _____
- ☐ Release HIV Related Information Initials: _____

I UNDERSTAND THAT

- This authorization will become effective immediately and will expire on _____ (date). If no date is specified, this authorization will expire one (1) year from the signature date
- I may revoke this Authorization at any time, in a written revocation sent to the Custodian of Records. However, I understand that my health information may have already been released.
- Information released by this Authorization might be re-disclosed by the recipient and might not be protected by the State and Federal Privacy Laws. I agree to release Premiere Surgical Specialists from liability for release and disclosure of released information.
- I am not required to sign this Authorization as a condition to obtain treatment or services. My signature on this Authorization is voluntary.

Signature of PATIENT ONLY: _____ Print Name: _____ Date: _____

Signature of Person Who is NOT the Patient: _____ Date: _____

Print Name: _____ Authority to Sign: _____
(Proof of Authority MUST be attached (except for parents)

Address: _____ Telephone: _____

Office Use Only

Date Fulfilled: _____ Fulfilled by: _____

Identification Presented: _____ Fee Collected: _____