Section A: This section must be completed for all Authorizations

Patient Name:	Birthdate:	Social Security No.:

Provider's Name:	Recipient's Name:
Southern Hills Hospital and Medical Center	
Provider's Address:	**Address 1:**
9300 West Sunset Road	**Address 2:**
Las Vegas, Nevada 89148	**City:** / **State:** / **Zip:**

This authorization will expire on the following: (Fill in the Date or the Event but not both).
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	*Date(s):*	*Description:*	*Date(s):*	*Description:*	*Date(s):*
☐ Face Sheet		☐ Lab/Path Records		☐ Physician Orders	
☐ Discharge Summary		☐ Imaging/Radiology			
☐ Emergency Room Records		☐ Cardiac Studies			
☐ History & Physical		☐ Nursing Notes ($0.60/pg)		☐ Itemized bill:	
☐ Consult Report		☐ Medication Record			
☐ Operative Report		☐ Progress Notes		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information ☐ YES ☐ NO

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patients's Representative:	Date:
Print Name of Patients's Representative:	**Relationship to Patient:**

SOUTHERN HILLS
HOSPITAL & MEDICAL CENTER

Authorization for Use and Disclosure of Protected Health Information (PHI)

PATIENT IDENTIFICATION

Section A: This section must be completed for all Authorizations

Patient Name:	**Birthdate:**	**Social Security No.:**

Provider's Name: Southern Hills Hospital and Medical Center	**Recipient's Name:**
Provider's Address: 9300 West Sunset Road Las Vegas, Nevada 89148	**Address 1:**
	Address 2:
	City: / **State:** / **Zip:**

This authorization will expire on the following: (Fill in the Date or the Event but not both).
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ Face Sheet		☐ Lab/Path Records		☐ Physician Orders	
☐ Discharge Summary		☐ Imaging/Radiology			
☐ Emergency Room Records		☐ Cardiac Studies			
☐ History & Physical		☐ Nursing Notes ($0.60/pg)		☐ Itemized bill:	
☐ Consult Report		☐ Medication Record			
☐ Operative Report		☐ Progress Notes		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
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4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information ☐ YES ☐ NO

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patients's Representative:	**Date:**

Print Name of Patients's Representative:	**Relationship to Patient:**

SOUTHERN HILLS
HOSPITAL & MEDICAL CENTER

Authorization for Use and Disclosure of Protected Health Information (PHI)

Original – Facility Copy – Individual (Patient or Patient Representative SH-1022 REV 04/09

PATIENT IDENTIFICATION