AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

	Initial here if requesting information from Summerlin Hospital Medical Center. Note: There will be a charge of $.60 per page for releases of PHI for all reasons other than continued patient care.
	Initial here if requesting information to be sent TO Summerlin Hospital Medical Center. (Attention: Health Information Management)
	Initial here if requesting access to review original medical records.

Patient Name at Time of Treatment _____ Date of Birth _____ Social Security Number _____

Street Address _____ Home Phone Number _____

City _____ State _____ Zip Code _____ Work Phone Number _____

This document authorizes Summerlin Hospital Medical Center to use and disclose Protected Health Information (PHI) as described below. Uses and disclosures of PHI will be consistent with Nevada and Federal law concerning the privacy of PHI. Failure to provide all information requested will delay action on this Authorization.

1. *Person(s)/Organization(s) authorized to release the PHI:* ☐ Summerlin Hospital Medical Center _____
2. *Person(s)/Organization(s) authorized to receive the PHI:* ☐ Summerlin Hospital Medical Center _____
3. *Purpose of Requested Use or Disclosure:* _____
4. *Description of the information included in Use or Disclosure:* *Treatment date(s):* _____ *to* _____

☐ Discharge Summary	☐ Pathology Report	☐ Outpatient Record	☐ Billing Record
☐ History and Physical	☐ Operative Report	☐ Physician's Orders	☐ Other (please specify):
☐ Lab Reports	☐ Progress Notes	☐ Nurses' Notes	_____
☐ X-Ray Report	☐ Emergency Room Record	☐ All PHI In Medical Record	_____

5. *By signing my initials next to the specific category of highly confidential information, I am authorizing Summerlin Hospital Medical Center to release the indicated type of information next to my initials pursuant to this Authorization from the treatment date(s) listed above.*

_____ HIV/AIDS	_____ Drug and Alcohol Information	_____ Genetic Information
_____ Mental Health Information	_____ Sexually Transmitted Disease Information	_____ Tuberculosis Information

6. *Please list a date or event at which point this Authorization will expire (not to exceed 1 year):*

NOTICE OF RIGHTS AND OTHER INFORMATION:

1. I understand that I have the right to revoke this authorization at any time. Such requests must be submitted in writing to the attention of Summerlin Hospital Medical Center, Health Information Management Department at 657 Town Center Drive, Las Vegas, Nevada, 89144. Phone: (702) 233-7589 Fax: (702) 233-7916. Cancellation of my authorization will be effective when Summerlin Hospital Medical Center receives my signed request, but it will not apply to the information that was used or disclosed prior to that date.
2. I understand that refusal to sign this authorization will have no effect on my enrollment, eligibility for benefits, or the amount a third party payor pays for the health services I receive.
3. I understand that the person or entity that receives this information may not be covered by the federal privacy regulations, in which case the information above may be redisclosed and no longer protected by these regulations. I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for the use and/or disclosure.
4. I have a right to receive a copy of this authorization. I may inspect or obtain a copy of the protected health information that I am being asked to use or disclose.

Signature of Patient _____ Date _____

Signature of Legal Representative _____ / Print Name _____ / Date _____ / Relationship To Patient _____

Witness _____ Date _____

☐ I Will Pick Up PHI
☐ Mail PHI
☐ Please Fax PHI To Physician Indicated

Reason Patient Unable to Sign _____

BAR CODE

RI0010 - Authorization of Health Info

SUMMERLIN HOSPITAL MEDICAL CENTER

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
(PMM# 79277406) (R 4/07) (IKON COPY CENTER)

ORIGINAL- MEDICAL RECORD CANARY- PATIENT

PATIENT IDENTIFICATION