UMC
UNIVERSITY MEDICAL CENTER
THE SYMBOL OF EXCELLENCE

# University Medical Center of Southern Nevada
# Authorization to Use & Disclose Protected Health Information

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

**(Please print)**

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Social Security # : _____ Dateof Birth: _____ Phone #: _____

Medical Record #: _____ Account #: _____

Specify method of receipt: ☐ Mail ☐ Call when ready for pickup

Persons/Organizations Authorized to Receive the Information:

_____

_____

Purpose of Requested Use or Disclosure:

_____

_____

Specify the dates of services requested: _____

Specify the information that may be Used or Disclosed:

_____

_____

[ ] see attached Document List

*The following items must be initialed to be included in the use and/or disclosure*:

☐ HIV/AIDS Related Information and/or Records
☐ Mental Health Information and/or Records
☐ Genetic Testing Information and/or Records
☐ Drug/Alcohol Information and/or Records

This authorization expires (enter date or event): _____

***PLEASE CONTINUE TO PAGE 2 TO COMPLETE THIS FORM***

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## NOTICE OF RIGHTS AND OTHER INFORMATION

- I understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of medical records and protected alcohol and drug abuse health information under 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided for by the regulations.
- I understand that the person or entity that receives the information may not be covered by the federal privacy regulations; in which case, the information described 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.
- I understand that UMC will not condition treatment on whether I sign this authorization. I understand that my refusal may affect my ability to obtain eligibility for benefits.
- I may cancel this authorization at any time. Cancellation of my authorization must be in writing, signed by me (or on my behalf), and delivered to UMC/CLARK COUNTY Privacy Officer, 1800 W. Charleston Blvd., Las Vegas NV 89102. Cancellation of my authorization will be effective when Clark County receives my signed request, but it will not apply to the information that was used or disclosed prior to that date.
- I have a right to receive a copy of this authorization. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

| | |
|---|---|
| **Print Client Name** | **Today's Date** |
| **Signature of Client or Client's Legal Representative** | |
| **Print Name of Legal Representative (if applicable)** | **Relationship to Client (if not the Client)** |