Authorization for Release / Disclosure of Protected Health Information:

MT. GRANT GENERAL HOSPITAL
PO Box 1510 Hawthorne, NV
Phone: (775) 945-2461
Medical Records direct phone:(775) 341-6118
Fax: (775) 945-0732

For Medical Record Staff use only:
Date Received:
Medical Record Number:
Date Complete / Initials:

Notice to the individual making this authorization:

1.This authorization shall become effective immediatley and shall remain in effect for one year from the date of signature.

2.Medical Records may take up to 10 business days to copy and send from the receipt of request date.

3. This authorization may be revoked in writing. The written revocation will be effective immediatley upon receipt, but will not apply to any information released prior to that date.

4. The recipient may not lawfully further use or disclose the PHI unless another authorization is obtained or such disclosure/use is permitted by law.

Patient Name:	Date of Birth:	
Address:		Phone Number:

I hereby authorize MGGH Other: ______________________ **to disclose my protected health information (PHI) / medical records to:**

Name:

Address:

Phone: Fax:

Dates of service / treatment: **(MUST BE COMPLETED)** ______________________

Description of information to be released:

_________ Acute / Observation Record _________ Clinic Record _________ All

_________ ER Record _________ Labs / X-rays / EKG _________ Other: _________

****The release of the following information requires a signature****

_________ HIV/AIDS, STD, Hepatitis, infectious diseases ______________________ Signature

_________ Drug / Alcohol ______________________ Signature

_________ Psychiatric ______________________ Signature

I understand my PHI / medical record may contain information about HIV/AIDS diagnosis or treatment, Drug and Alcohol use ,history ,and treatment, and psychiatric diagnosis and treatment. By signing below I authorize release / disclosure of my PHI / medical record even if such information is contained within those documents.

Reason for request: _________ Continuity of care _________ Legal _________ Insurance

_________ Other (describe): ______________________

Signature of Patient or patients representative:	Relationship to patient:	Date:

Form: Record Request 9/2010 A.Vincent

***** Representative other than parent, or legal guardian must have written / verbal permission from patient to receive PHI*****