LAS VEGAS
SPINE&PAIN
CENTER

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____SSN: _____

I hereby authorize:

Las Vegas Spine and Pain Center

□ 3270 North Buffalo Drive, Las Vegas, NV 89129 Phone (702)-676-2000, Fax (702)-676-2042

□ 4560 S. Eastern Ave. Suite 18, Las Vegas, NV 89119 Phone (702)-676-2000, Fax (702)-676-2042

To release records to:

_____

_____

_____

I hereby authorize:

_____

_____

_____

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I request and authorize the above names health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released may include information regarding the following condition(s) which may be protected by Federal Law, Drug/Alcohol Abuse, Mental Health Problems, Sickle Cell Anemia, HIV/AIDS Infection, Sexually Transmitted Diseases.

INFORMATION TO BE RELEASED:

Dates of service: _____

□All records

□Consultation(s)

□Procedure Report(s)

□Pathology Report(s)

□Radiology Report(s)

□Laboratory Report(s)

□Billing Information

□Other (Specify)_____

FOR THE PURPOSE OF:

□Further Medical Treatment

□Moving/Relocating

□At the request of the individual

□Insurance claims

□Attorney/court case

□Change Physicians

□Other (specify):_____

Confidentiality notice: The documents accompanying this release contain confidential information belonging to the sender. This information is legally privileged and intended for the use of the individual named above. If you are not the intended recipient, please notify the sender and dispose of the information received. Use of this protected information by anyone other than the recipient is strictly prohibited. This request will expire 90 days from signature date.

X _____ Prepared by: □Patient □Parent of minor □Legal Guardian

Signature of Applicant **Date**