DESERT PARKWAY
Behavioral Healthcare Hospital

Authorization for Release of Information (Medical Records)

Please note: medical records copied for reasons other than continuity of care are subject to a copy fee of $0.60 per page (NRS 629.061).
Complete, sign and date the form. To verify your identification and validate your authorization, we require that you include a legible copy of a valid government issued photo I.D. (e.g., driver's license, military I.D. or state I.D.).
Mail, fax (702-776-3595), email (alv.him@desertparkway.com) or personally deliver your paperwork to the facility.

Section *A: Scope of Authorization*

PATIENT NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **CITY, STATE, ZIP:** _____

Last four (4) digits of Patients' Social Security Number**:** _____ **Physician:** _____

Telephone number: _____ **Email:** _____

I hereby authorize DESERT PARKWAY BEHAVIORAL HEALTHCARE HOSPITAL, LLC to ☐ send or ☐ obtain information/copies of protected health information from my mental health/substance abuse medical record to:

_____
(Name of person, facility, and or institution where medical records are to be sent or obtained)

_____ _____ _____
(City, State, and Zip code) (Telephone Number) (Fax Number)

☐ Complete copy of the medical record

☐ Most recent medical record ONLY; OR ☐ the following (Identify specific information to be released, for example specific parts of the records only including dates and attaching additional pages if necessary):

_____

The information will be used/disclosed for the following purpose:

☐ Personal ☐ Continuity of Care ☐ Billing/Insurance Claims ☐ Litigation ☐ Other (please explain) _____

I understand that this medical record may include information concerning psychiatric diagnoses, drug abuse, alcoholism or communicable or venereal diseases (including but not limited to diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome “AIDS”). With this knowledge, I hereby give my consent to release the requested information from the above-referenced medical record, including any information concerning the patient’s/resident’s identity.

NOTICE TO PARTY RECEIVING DRUG/ALCOHOL ABUSE INFORMATION:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Section *B: Patient's Rights*

I understand that the Facility disclosing information pursuant to this authorization cannot condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization. Further, I understand that I may inspect or copy any information used or disclosed under this authorization and that I may revoke this authorization in writing at any time by notifying the Facility in writing, except to the extent that action has been taken in reliance on this authorization prior to the revocation.

Section *C: Patient Authorization*

By my signature below, I authorize the above-named entities to use, disclose or receive the information identified in this authorization and understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by the recipient and no longer protected by those regulations.

I hereby agree to release and discharge the Facility, its parent, affiliates, officers, directors, employees, attorneys, agents, assigns and all other persons acting on its behalf, from all claims arising out of or in any way related to compliance with this request.

This authorization shall expire on _____/_____/_____ OR _____
(event)

(If no expiration date or event, this authorization will expire six (6) months from the date on which it was signed.)

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of **Parent/Guardian** (If patient is under 18 years of age) or **Guardian** (with papers or personal representative issued by Court) Relationship Date

**NOTE: Pursuant to applicable state laws governing a patient's / resident's right to privacy and the confidentiality of medical records, any Attorney In Fact pursuant to a Power of Attorney, Legal Guardian or Personal Representative of an Estate executing this Authorization on behalf of a Patient/Resident must provide governing documentation (e.g., Durable Power of Attorney for Healthcare, Letters Testamentary/Administration, etc.) prior to the release of any medical records