AstranaCare

8880 W. Sunset Rd Ste 320, Las Vegas, NV 89148
Fax: 702-940-7576

Authorization to Disclose Protected Health Information (PHI)

This request to release medical records will be returned if not completed in its entirety

Patient name: _____ Medical record number: _____

Address: _____ City: _____ State: _____

Zipcode: _____ Date of birth: _____

I authorize the use or disclosure of the above named individual's Protected Health Information as described below:

1 **The type and amount of information to be used or disclosed is as follows**

Include dates where appropriate – **From** (date): _____ **Through** (date): _____

☐ **Entire record**, or:

☐ Medication List
☐ Laboratory Results
☐ Other: _____

☐ Immunization Records
☐ X-Ray/Dexa Reports

☐ Provider Notes
☐ Cardiology Reports

2 **Please initial for release of the following information even if you checked "Entire Record" above**

_____ HIV Information
_____ Addictive Behavior
_____ Child & Domestic Abuse History
_____ Communicable and Sexually Transmitted Disease
_____ Psychiatric / Mental Health Information
_____ Genetic Test Results
_____ Substance Abuse

Note: Information pertaining to substance abuse diagnosis or treatment requires completion of the Consent for Release of Confidential Health Information under 42 C.F.R. Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records.

3 **Reason for request:** (please check one)

☐ Medical Care ☐ Insurance ☐ Personal ☐ Attorney ☐ Other _____

4 I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If left blank, this authorization will expire in six months

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5 **This information is to be disclosed to** ☐ Requestor ☐ the following individual or organization

Name	Phone number	Fax number
Address	City, State, Zip	

6 I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department and obtain a copy of the Privacy Notice.

7 **I wish to receive this information on** ☐ Paper

Signature of Patient: *Date of Signature*

Signature of Parent, Guardian or Representative (if necessary): *Date of Signature*
(If Personal Representative, attach supporting documentation)

Routed to:_____
By:_____
Date: _____
Completed: ___Y ___N
Scanned by: (initial)_____
Photo ID checked by: _____

NOTE: There is a charge of $0.60 per page for copies of records unless information is being disclosed to a medical facility. Please allow 7-10 business days from date of receipt by Medical Records Dept. Phone: 702-776-7968 M-F, 8am-4pm

Astrana Care does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.