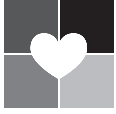

ST. ROSE
PEDIATRICS

Authorization For Release of Medical Information

Patient Name:____DOB:_______________

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 C.F.R. 164.508]. It authorizes Physician's Primary Care of St. Rose Pediatrics to disclose certain protected health information about me.

Check and/or specifically describe the information to be used or disclosed:
____Complete Health Record ____
____Specific Dates of Service ____
____Specific Conditions ____

I authorize the information to be released to: ________________________________
____

I authorize __________________________________to release my medical information.
This information is to be disclosed or used for the purpose of: Continuity of Care__________
____
____

This authorization will be in force and in effect until_________at, which time this authorization expires.

I understand that this WILL NOT include the following information unless indicated and initialed below:
___Intials_____AIDS or HIV infection ___Initials_______STD Information
___Initials_____Behavioral Health/Mental Health Care ___Initials_______TX for Alcohol/Drug Abuse

Are you leaving the practice? ____Yes _X_No
Reason for transfer of records: ____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected under the federal HIPPA Rule. I may revoke this authorization at any time, except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted in writing.

____________________________ ____________ ____________________
Signature of Patient or Legal Representative Date Relationship of Patient

(702) 564-8556
(702) 564-4485 (Fax)

2350 W. Horizon Ridge Pkwy
Henderson, NV 89022

8980 W. Cheyenne Ave
Las Vegas, NV 89129

6980 S. Cimarron Road, Ste 100
Las Vegas, NV 89113

Form ARMD-v2(IR) (6/2020)