Sunrise Pediatrics

Maryland Office: (702) 254-KIDS (5437)

Rainbow Office: (702) 361-KIDS (5437)

Smoke Ranch Office: (702) 820-KIDS (5437)

SunrisePediatricsLasVegas.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize
Facility Name: _____

Address:_____

City: _____ State: _____ Zip Code:_____

Phone Number: _____, to release protected health information of the patient named above to: **Sunrise Pediatrics**

☐ 3061 S. Maryland Pkwy, #101
Las Vegas, NV 89109
Phone Number: (702) 254-5437
Fax Number: (702) 254-7354

☐ 7875 S. Rainbow Blvd, #102
Las Vegas, NV 89139
Phone Number: (702) 361-5437
Fax Number: (702) 260-8799

☐ 7200 Smoke Ranch Rd. #150
Las Vegas, NV 89128
Phone Number: (702) 820-5437
Fax Number: (702) 444-3423

This authorization for release of medical information covers the period of healthcare from:

❑ _____ to _____

❑ All healthcare information

❑ Other: _____

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RESTRICTION: Only medical records originated through this health care facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I may revoke this authorization at any time. I understand that if i revoke this authorization 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. I understand that the revocation will not apply to my insurance company when law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If i fail to specify an expiration date, event or condition, this authorization will expire 1 year from date signed.**

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 any questions about disclosure of my health information, i can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information an do hereby acknowledge that i am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Signature of patient or Parent/Guardian (if patient is a minor) Date

_____ _____

Printed name of patient or Parent/Guardian (if patient is a minor) Relationship