HAND SURGERY SPECIALISTS OF NEVADA

HIPAA COMPLIANT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

_____	_____
Name of Patient	Date of Birth
_____	_____
Street Address	City, State, Zip Code
Authorizes:	**Release to:**
_____	_____
Name of Health Care Provider/ Plan/ Other	Name of Health Care Provider/ Plan/ Other
_____	_____
Street Address, City, State, Zip Code	Street Address, City, State, Zip Code
_____	_____
Phone & Fax Number	Phone & Fax Number

Format to be provided: _____Printed Copy _____Electronic Copy _____ Date of Service: _____

Information to be released:

_____ Office Visit	_____ Procedure Reports	_____ Entire Record
_____ In-Office X-Ray Images	_____ Laboratory Results	_____ Medications
_____ Consultations	_____ Diagnostic Results	_____ Billing

_____ Other: _____

Purpose of Disclosure: _____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, which must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy stands and my health information may be re-disclosed without my authorization.

Your rights with respect to this authorization:
1) I understand this consent may be revoked at any time, with the exception and to the extent, which disclosure of this information has already occurred prior to the receipt of revocation by the above named provider. 2) I understand if written revocation is not received, this authorization will be considered valid for a period not to exceed 12 months from the date signed. To initiate revocation of this authorization, I must submit my request in writing to the "Authorizes" entity above. 3) I understand a photocopy of this authorization is to be considered as valid as the original. 4) I understand the information used or disclosed pursuant to this authorization may be transmitted electronically and may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law. 5) I understand that I have the right to refuse to sign this authorization, am signing this authorization voluntarily, and that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization. 6) I have the right to receive a copy of this authorization and any records obtained with its use. 7) I understand this consent includes disclosure of Alcohol, Drug Abuse and/or Psychiatric records, Sexually Transmitted Disease and HIV/AIDS information. 8) I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information, or obtain copies of my health information, by contacting the Privacy Officer.

Expiration Date: This authorization is good until the follow date(s) _____or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that I accurately reflects my wishes.

_____	_____
Signature of Patient or Legal Representative	Date

If signed by other than the patient, select authority and provide documentation:

_____Parent of minor child _____Power of Attorney _____Representative of Deceased's Estate _____Representative of Incapacitated Adult

Witness: _____