PATIENT CONSENT/AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Once the requested Protected Health Information (PHI) is disclosed, the Privacy Regulations may no longer protect this information if the PHI recipient elects to redisclose the PHI.

I _____ _____ _____
Patient Name | Social Security Number (last 4 digits) | Phone Number

Date of birth _____ hereby authorize, request, and direct:

Spring Mountain Treatment Center, 7000 W. Spring Mountain Rd. Las Vegas NV 89117

PHONE NUMBER: (702-873-2400) MEDICAL RECORDS FAX NUMBER: (702-873-1859)

To: ☐ Disclose to: ☐ Receive from:

_____ _____
Name of Person | Name of Organization

_____
Address of Person or Organization

_____ _____
Phone Number | Fax Number

The following information from my medical record relative to treatment I received from: _____ to _____
Date | Date

PLEASE CHECK REQUESTED ITEMS:

☐ Verbal Communication with: _____

☐ Discharge Summary	☐ Consultation Reports	☐ Discharge/Continuing Care Plan
☐ Intake Assessment	☐ X-Ray Report	☐ Psychiatric Evaluation
☐ Psych-Social History Assessment	☐ Physician Progress Notes	☐ History and Physical Exam
☐ Treatment Plan	☐ Physician Orders	☐ Psychological Testing
☐ Laboratory Data	☐ Medication Records	

☐ Other: _____

This information is released for the following purpose and that purpose only. No other use or further disclosure of such information is permitted

Purpose of Disclosure ☐ **Personal** ☐ **Disability** ☐ **FMLA**
☐ **Treatment** ☐ **Legal**
☐ **Continuation of Care** **Other:** _____

I understand that if the specific record information that is the subject of this Authorization contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, the disclosure I am hereby authorizing will include that information.

I understand that I can revoke my authorization in writing at any time, with the exception that the revocation will not apply to information already released in response to this authorization. If not previously revoked, this consent shall expire within 90 days from date signed or on _____whichever date is later.

_____ _____
Signature of Patient | Date

_____ _____
Signature of Parent, legal guardian, authorized representative | Date

_____ _____
Signature of Witness | Date

IF YOU HAVE NOT RECEIVED YOUR RECORDS WITHIN 30 DAYS OF THE REQUEST, NOTIFY THE MEDICAL RECORDS DEPARTMENT AT 702-873-2400.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.