MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient name: _____

Address: _____

_____

Phone: _____ Date of Birth: ____/____/_____

I, _____, am requesting that
Memor Health (Yvette Kaunismaki M.D., P.C. dba)

☐ release health information TO

☐ obtain health information FROM

the person/company/facility/agency listed below:

_____

Name of Person or Entity (Please print) Phone

_____

Address (City, State, and Zip) Fax

Information to be disclosed:

****(check all that apply)*

____ All Records ____Abstract/Summary ____ Lab/Pathology Records

____Pharmacy/Prescription Records ____ Mental Health Records ____ History/ Physical Exam

____ Chemical Dependency/ Substance Abuse Records ____ Consultations

____ Other (describe specifically) _____

_____

****Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Purpose of Release:

_____ Continuing Care _____ Transfer of Care _____ Insurance Payment/ Claim

Other: _____

Delivery Method:

_____ (U.S. Mail) Memor Health - 10405 Double R Blvd - Reno, NV 89521

_____ FAX: (775) 827-2488

_____ E-mail: schedule@memorhealth.com

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

This authorization's automatic expiration date will be one year from the date of my signature or _____/_____/_____, whichever is sooner. Further, if the therapeutic relationship is terminated by the patient or the therapist, this authorization will expire immediately.

_____ _____

Signature of patient or patient representative*** Date

_____

Printed name of patient or patient representative***

***Representative (i.e. guardian, parent, power of attorney for healthcare, executor)