

authorization for disclosure of confidential health information

I, _____, (DOB: _____) authorize the information specified below to be disclosed as follows:

FROM TO



DR. JOSH HAMILTON APRN, LLC
 9205 W. RUSSELL RD. STE 240-224
 LAS VEGAS, NV 89148-1425
 Secure Fax: 702.302.4161

FROM TO

Person/Org: _____
 Address: _____

 Phone: _____ Fax: _____

Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment by Dr. Josh Hamilton APRN (check each item):

	YES	NO		YES	NO
Assessment & diagnostic summaries	<input type="checkbox"/>	<input type="checkbox"/>	Billing payment records	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric evaluation	<input type="checkbox"/>	<input type="checkbox"/>	Medication regimen	<input type="checkbox"/>	<input type="checkbox"/>
Medical history & physical exam	<input type="checkbox"/>	<input type="checkbox"/>	Discharge summary	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory reports (excluding HIV)	<input type="checkbox"/>	<input type="checkbox"/>	Progress reports	<input type="checkbox"/>	<input type="checkbox"/>
Attendance record	<input type="checkbox"/>	<input type="checkbox"/>	Substance abuse/CDIOP	<input type="checkbox"/>	<input type="checkbox"/>
Progress notes	<input type="checkbox"/>	<input type="checkbox"/>	Verbal exchanges	<input type="checkbox"/>	<input type="checkbox"/>
Treatment plan	<input type="checkbox"/>	<input type="checkbox"/>	Treatment goals	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____				<input type="checkbox"/>	<input type="checkbox"/>

If information in my records pertains to HIV/AIDS, I expressly DO DO NOT authorize Dr. Hamilton's office to disclose such information pursuant to this authorization. Check if not applicable.

I am requesting that this information be disclosed for the purpose(s) of _____

I am aware of the confidential and/or privileged nature of the information being disclosed and understand the benefits and/or disadvantages of disclosing such information. I hereby release Dr. Josh Hamilton APN and his affiliates, representatives and assigns from all legal liabilities that may result from the release of this information.

This authorization shall be in full force and effect until _____. If no expiration date is provided, this authorization shall expire one hundred eighty (180) days after the date on which I signed below.

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the medical records department at Josh Hamilton's office. I understand that a revocation is not effective if Josh Hamilton's office has already taken actions in reliance upon this authorization. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy laws and regulations.

I understand that Josh Hamilton's office will not condition my treatment, payment or enrollment or eligibility for benefits upon whether or not I provide this authorization.

 Patient/Legal Guardian Signature

 Date

 Patient/Legal Guardian Name (PRINTED)

 For Legal Guardian, indicate authority to sign

 Witness Signature

 Date

Notice to Recipient: This authorization provides for a release of information about an individual whose confidentiality is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (45 CFR §160-164) as well as 42 CFR Part 2 and 42 USC §290dd-2 and state confidentiality laws. No information disclosed from this authorization may be redisclosed without the specific written consent of the individual to whom such information pertains.