AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: _____ **Date of Birth:** _____
Last First Middle

Recipient of Health Information: I voluntarily authorize release of my information to:

Name: _____

Address: _____

Fax Number: _____ Phone Number: _____

I authorize **Mountainview Medical Associates 1701 County Rd Ste. H, Minden, NV 89423 (P) 775-782-3933 (F) 775-782-1127** to release my information to the above healthcare provider.

Purpose: I understand that the specific purpose of the Authorization is at the request of the patient.

Information to be disclosed: This authorization permits the above provider to disclose the following medical records:

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental, or physical condition and any treatment received by me **

☐ All of my health information described above except for the following:

_____

☐ Only the following records or types of health information: (Insert dated of treatment, types of treatment, or other designation:

_____

Terms: This authorization is to remain in place until the provider fulfills this request.

Refusal to sign/right to revoke: I may refuse to sign or may revoke this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment by my health care provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Officer at the address listed above. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Patient/Guardian Signature: _____ **Date:** _____

Patient/Guardian Print Name: _____

Signature of Witness: _____

**** NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law or mental health records that are protected by the Lanterman-Petris-Short Act.**