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
840 S. RANCHO DR. STE 4-433
LAS VEGAS, NV 89106-3837
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	☐	☐	Billing payment records	☐	☐
Psychiatric evaluation	☐	☐	Medication regimen	☐	☐
Medical history & physical exam	☐	☐	Discharge summary	☐	☐
Laboratory reports (excluding HIV)	☐	☐	Progress reports	☐	☐
Attendance record	☐	☐	Substance abuse/CDIOP	☐	☐
Progress notes	☐	☐	Verbal exchanges	☐	☐
Treatment plan	☐	☐	Treatment goals	☐	☐
Other (specify) _____				☐	☐

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.