

## Authorization for Release of Protected Health Information

**I authorize the following facility(s):**

- Dignity Health St. Rose Dominican Neighborhood Hospital – Blue Diamond
- Dignity Health St. Rose Dominican Neighborhood Hospital – North Las Vegas
- Dignity Health St. Rose Dominican Neighborhood Hospital – Sahara
- Dignity Health St. Rose Dominican Neighborhood Hospital – West Flamingo

**to release information from the record of:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip code

Patient Phone Number: \_\_\_\_\_

**as described below, the information will be released to:**

Facility/Person to Receive Records \_\_\_\_\_

Phone: \_\_\_\_\_ Fax/Email: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip code

I have been a patient at your facility or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way. The facility cannot require me to sign the authorization in order to receive treatment.

**Place a check by types of records desired:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Entire Clinical Record          | <input type="checkbox"/> History & Physical Exam  | <input type="checkbox"/> Physician Orders           |
| <input type="checkbox"/> Discharge Summary               | <input type="checkbox"/> Medication Administration Records  | <input type="checkbox"/> Physician Progress Reports |
| <input type="checkbox"/> Laboratory Reports/Tests        | <input type="checkbox"/> Psychiatric/Psychological Evaluation   |   |
| <input type="checkbox"/> EKG Report                      | <input type="checkbox"/> Radiology Report   |   |
| <input type="checkbox"/> Nurses Notes                    | <input type="checkbox"/> Pathology Report   |   |
| <input type="checkbox"/> Emergency Department Report     | <input type="checkbox"/> Abstract ( <i>history/physical, consults, labs, EKGs, ORs, D/C summaries, ER reports</i> ) |   |
| <input type="checkbox"/> Consultation Reports            | <input type="checkbox"/> Billing or other business records ( <i>specify</i> ): _____                                |   |
| <input type="checkbox"/> Other ( <i>specify</i> ): _____ |   |   |

**HIV, mental health, and drug/alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release:**

- |                                       |                              |  |
|---------------------------------------|------------------------------|--|
| <input type="checkbox"/> Drug/Alcohol | <input type="checkbox"/> HIV | <input type="checkbox"/> Mental Health (Psychiatric) |
|---------------------------------------|------------------------------|--|

**Reason for Request:**

- |   |                                     |   |   |
|---|-------------------------------------|---|---|
| <input type="checkbox"/> Continuing treatment | <input type="checkbox"/> Employer   | <input type="checkbox"/> Insurance                            | <input type="checkbox"/> Study/Research |
| <input type="checkbox"/> Legal                | <input type="checkbox"/> Disability | <input type="checkbox"/> I do not wish to disclose the reason |   |
| <input type="checkbox"/> Other: _____         |                                     |   |   |

Dates of Service for record requests: \_\_\_\_\_

This authorization will expire in six months or: \_\_\_\_\_

A disclosure statement, as required by law, will accompany all records released. Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.

## Authorization for Release of Protected Health Information

I understand that this authorization is subject to revocation at any time, except to the extent that Dignity Health St. Rose Dominican has already taken action in reliance upon it or to the extent previously disclosed within the HIPAA NOTICE OF PRIVACY PRACTICES for Treatment, Payment, and/or Business Operations. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing and deliver to the Privacy Officer. My decision to revoke the authorization may result in my insurance company not being able to pay for my medical care, and I understand that I may be responsible for payment of the claim. I understand that recipients may redisclose information which I have authorized them to receive, and the information will no longer be protected by federal privacy regulations. If I am physically unable to sign, I may provide oral authorization if witnessed by two (2) staff members.

Patient or Representative Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

If representative, give relationship and authority to act \_\_\_\_\_

**\*\*If authority to act is a Power of Attorney, supporting documentation must be included with this request.\*\***

Identity of requestor verified via \_\_\_\_\_ Photo ID \_\_\_\_\_ Matching Signature \_\_\_\_\_ Other, Specify \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

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All release of information requests must be sent directly to the corresponding facility. The provider's office should be contacted directly to obtain their fax number. Below is the contact information for each hospital.

**Dignity Health St. Rose Dominican  
Neighborhood Hospital  
Blue Diamond**

Attn: Medical Records Dept.  
4855 Blue Diamond Rd.  
Las Vegas, NV 89139  
Phone: 702-216-7305  
Fax: 702-634-3000

**Dignity Health St. Rose Dominican  
Neighborhood Hospital  
North Las Vegas**

Attn: Medical Records Dept.  
1550 W. Craig Rd.  
North Las Vegas, NV 89032  
Phone: 702-777-3615  
Fax: 702-642-0808

**Dignity Health St. Rose Dominican  
Neighborhood Hospital  
Sahara**

Attn: Medical Records Dept.  
4980 W. Sahara Ave.  
Las Vegas, NV 89146  
Phone: 702-216-7365  
Fax: 702-367-0565

**Dignity Health St. Rose Dominican  
Neighborhood Hospital  
West Flamingo**

Attn: Medical Records Dept.  
9880 W. Flamingo Rd.  
Las Vegas, NV 89147  
Phone: 702-216-7335  
Fax: 702-253-2460