NEVADA FERTILITY Institute

8530 W Sunset Road, Suite 310
Las Vegas, NV 89113
Main: (702) 936-8710 • Fax (702) 936-8711

MEDICAL RECORD RELEASE
NFI AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION (PHI)

This Authorization is per Federal Privacy Laws

Patient Information:

Last Name _____ First _____ Middle _____

Maiden Name _____ Address _____

City _____ State _____ Zip _____

SS Number _____-_____-_____ Date of Birth _____/_____/_____ Phone ( ) _____-_____

I, the above identified person, do hereby authorize NFI to release my PHI as indicated – Identify individual/group/entity and list addresses.

From: **Nevada Fertility Institute**
8530 W Sunset Rd, Suite 310
Las Vegas, NV 89113
P: (702) 936-8710 F: (702) 936-8711

To: _____

_____

_____

I understand that this authorization is voluntary and that it may include information relating to *AIDS, HIV infection, behavioral health services/psychiatric care, and treatment for alcohol and/or drug abuse.* I understand that if the person/entity that receives my Protected Health Information is not covered by Federal Privacy regulations, the PHI described below may be re-disclosed by such person or entity. I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

This authorization covers the following periods of healthcare:

☐ All Periods of Healthcare ☐ From _____/_____/_____ To _____/_____/_____

Protected Health Information (PHI) to be used or disclosed (check box or boxes):

Entire Medical Record (does NOT include radiology images, billing records and psychotherapy notes)

- ❑ Office Visits
- ❑ Consultation Reports
- ❑ Radiology Reports
- ❑ Radiology Images
- ❑ Laboratory Reports
- ❑ Operative Report
- ❑ Psychotherapy Notes
- ❑ Billing Records (itemized statements, EOB, HCFA1500)
- ❑ Other (please specify) _____

This information is being disclosed for the following purposes:

- ❑ Legal Reasons
- ❑ Continued Care and Treatment
- ❑ Obstetrical Care
- ❑ At the Request of the Patient
- ❑ Insurance
- ❑ Worker's Compensation
- ❑ Personal Use
- ❑ Disability

Other (Explanation) _____

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization or per law. Written revocation must be sent to the person that I authorized to release my information.

This authorization will expire in 120 days unless otherwise specified (date or specific event):

I hereby certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

Patient Signature _____ Date ____/____/____

PLEASE ALLOW UP TO 30 BUSINESS DAYS FOR PROCESSING OF MEDICAL RECORDS