# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient_____ DOB_____ MR#_____FIN#_____
*(Internal use only)* (*Internal use only)*

I authorize:
□Valley Hospital/DSH FED/NLV FED/Elite □Spring Valley Hospital/Blue Diamond FED □Summerlin Hospital/FED
□Henderson Hospital/GVR FED/Cadence FED □Centennial Hills Hospital/West Craig FED/ValleyVista FED
□Desert Springs Hospital □West Henderson Hospital □Spring Mountain Treatment Center
□ Other_____

To disclose medical information or copies of my medical records to (physician, agency, individual):
Name_____
Address_____
City, State, Zip_____
Phone_____

Please select one of the following delivery methods:
□ Mail to above address □ Email _____ □ Fax to provider_____

Reason for release: □ Personal □ Continuity of care □ Legal □ Disability □FMLA □ Other (specify)_____
Date(s) of service _____

**Description of Information to be Released: (***(Check ALL that apply)*
□ Industry Standard (Discharge Summary, History & Physical, Consult Reports, Operative Reports, Test Results)

| | | | |
|---|---|---|---|
| □ Discharge Summary | □ History and Physical | □ Operative Reports | □ Physician Orders |
| □ ED Record Only | □ Progress Notes | □ Radiology Reports | □ EKG/EEG |
| □ Consultation Reports | □ Pathology Reports | □ Lab Reports | □ Radiology Images (CD) |
| □ Medication Records | □ Intake Assessment | □ Treatment Plan | □ Psych-Social History Assessment |
| □ Psychiatric Evaluation | □ Psychological Testing | □ Billing Record | □ All Records |

□ Other (specify) _____

List a date or event at which point this Authorization will expire. This date or event is not to exceed one year from the date of the request. If no date is entered, this authorization will expire one year post the date of signature. (Fill in the Date or the Event but not both.)
**Date:** **Event:**

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ **(Initial)**

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise in the addendum to this release form.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

_____
Signature of patient/parent/guardian/legal representative Date

_____
If not patient, indicate relationship (Proof may be required) Witness

BAR CODE

RI0030

The Valley Health System®

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**
**(PMM# 55882) (R 4/25) (FOD)**

PATIENT IDENTIFICATION

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

In accordance with **NRS 629.061.1**, the following is the state of Nevada's policy for requesting copies of medical records for a deceased patient.

One Of The Following Must Be Presented:

***Handwritten Will***
A handwritten will is valid in Nevada if there is a sole beneficiary and it is signed and dated by the decedent. No witness or notary signature/stamp is required. It is assumed (and accepted) that the sole beneficiary is Executor. A non-interested Third Party must sign an affidavit stating that the signature of the decedent is authentic.

***Regular Will***
This must state that the decedent was in sound mind, over 18 and not under duress at the time of the will's creating. It must be witnessed by two other people and notarized to be "self-proving" (i.e. valid).

***Ex Parte Petition For Order To Release Medical Records***
An order to release medical records can be issued by Probate specifically to authorize an individual to obtain the medical record of the decedent provided that there are no assets in the estate. This process has no cost and can be ready the same day.

If none of the above is available, see below:

***Probate***
If there is no valid will, the petitioner must request a hearing with Probate to attain an "Order for Release of Medical Records". It can take 2-3 weeks from the time of the application to the actual hearing. You must contact the office of the Probate Court for additional information.

Probate Specialist
District Court Probate Office
Phoenix Building
10th Floor, Suite 1060
330 South Third Street, Las Vegas, NV 89101
Phone: 702-455-2650, Fax: 702-455-5551

Hours: Monday-Friday 8AM-5PM
(Note: Not accepting paperwork after 3:30PM; Office Closed for Lunch 12-1PM and on Thursdays 3-5PM)

Thank you for your cooperation.

Release of Information
Health Information Management Department

Rev: 10/2015