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## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

|   |   |                        |
|---|---|------------------------|
| _____<br>Patient Name   | _____<br>Contact Number   | _____<br>Date of Birth |
| <b>Authorizes:</b><br>_____<br>Name of Healthcare Provider/Plan/Other | <b>Release To:</b><br><u>Nevada Advanced Pain Specialists</u><br>Name of Healthcare Provider/ Plan/ Other |                        |
| _____<br>Address  | <u>5578 Longley Lane, Reno, NV 89511</u><br>Address   |                        |
| _____<br>Phone/ Fax   | <u>775-284-8650</u> <u>775-284-8654</u><br>Phone/ Fax   |                        |

### Information to be released:

entire record       physical therapy       billing  
 progress note       lab results       other: \_\_\_\_\_  
 procedure notes       imaging

Dates of service: \_\_\_\_\_ to \_\_\_\_\_

Reason for Disclosure: CONTINUATION OF CARE.

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand that this authorization is subject to revocation at any time, except to the extent that the individual or entity that is to make the disclosure has already taken action in reliance upon it. . A copy, electronic copy, image, or facsimile of this authorization is as valid as the original.

I understand that the person(s) and/or organization(s) above that I am authorizing to use/disclose my information may not condition my treatment, payment, or eligibility for healthcare benefits on my decision to sign this authorization.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

This authorization is valid for 12 months following the date of my signature shown below.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Recipient