

RECORDS RELEASE-PYRAMID HEALTH CENTER

Name of Patient _____ Date of Birth _____

I HEREBY AUTHORIZE THE RELEASE OR REVIEW OF THE FOLLOWING INFORMATION FROM AND TO THE PARTIES NAMED HERE:

FROM: Pyramid Health Center
Facility or Physician's Name

To: _____
Facility or Physician's Name

9732 State Rt. 445, #342

Address

Address

Sparks, NV 89431

City, State, Zip Code

City, State, Zip Code

Phone Number/Fax Number

ALL EMR RECORDS C-CDA FORMAT. FULL RECORDS AVAILABLE UPON REQUEST.

Reason for release of records: Transfer of Care

Expiration Date: This authorization is good until _____ or for 90 days from the date signed unless revoked by me in writing and submitted to the privacy officer at Pyramid Health Center.

I understand that the information released may include:

- Drug Abuse Sickle Cell Anemia Alcohol Abuse Human Immunodeficiency Virus (HIV)

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information could be re-disclosed without my authorization.

I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization.

I understand that I have a right to receive a copy of this authorization. I release the person/agency disclosing this information from any liability arising from the release of the information to the person/agency designated above.

Signature of Patient

Date

Signature of Guardian/Representative

Date

Signature of Witness

Date