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

2415 Pyramid Way #A
Address

Sparks, NV 89431
City, State, Zip Code

775-356-6040 Fax 877-384-8038
Phone Number/Fax Number

To:_____
Facility or Physician's Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number/Fax Number

ALL EMR RECORDS C-CDA FORMAT

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 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. Copy requested & received:
_____ no _____yes (please initial)

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