AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) By Joseph J. Schifini, MD, LTD. (JJS)

Patient Name: ____
Last First M.I. (Previous or Other Names Used)

Address: ____

____

Date of Birth: ____

If this Authorization is for any purpose other than the release of PHI for personal reasons, please state the purpose below:

I authorize the release of medical records from:

Joseph J. Schifini, MD, LTD
600 S. Tonopah Drive
Suite 240
Las Vegas, NV 89106

Please release requested medical records to:

Name: ________________________

Address: ________________________

City: ________________________

State: ________________________

ZIP: ________________________

Telephone Number: ( ) -

Fax Number: ( ) -

I specifically authorize the use and disclosure of the following PHI: **(Please provide a detailed description of the particular data and period of time you are requesting)**

□ Emergency Records
□ Clinic Records
□ Lab Reports
□ Shot Records
□ Slides
□ Hospital Records
□ Radiology Reports
□ Radiology Films
□ Pathology Reports
□ Other ____________________

This authorization will expire on the 180th day of the signing unless a lesser date is specified below:

By signing this Authorization Form, I understand that I am giving my authorization for JJS to use and/or disclose my protected health information (PHI) as described above. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care. If you are requesting psychotherapy session notes maintained by a mental health provider, a separate authorization form must be completed. I understand that I may revoke this authorization at any time by notifying JJS in writing to Joseph J. Schifini, MD, LTD Health Information Management Department, 600 S. Tonopah Drive, Suite 240, Las Vegas, Nevada 89106 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by JJS before JJS received my written notice of revocation. If neither federal nor Nevada privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Nevada privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that I am not required to sign this Authorization Form in exchange for the patient receiving treatment from JJS.

____ ______________

Signature of Patient or Authorized Personal Representative **Date**

____ ______________

Relationship to the Patient (If signed by a Personal Representative) **Date**