ENSIGN Family Medicine, LLC

Sanford F. White, M.D., M.P.H.
5771 South Fort Apache Rd. Ste # 100,
Las Vegas, NV 89148
Phone: (702) 951-3400
Fax (702) 951-3403

AUTHORIZATION

FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

This Authorization authorizes the release of Protected Health Information pursuant to 45 CFR Parts 160 and 164.

Patient Name (please print):_____ **Date of Birth:**_____

I. The information covered by this authorization includes but not limited to:

Complete medical records	Lab results
X-rays	Progress notes
Correspondence	Insurance information
Other (please specify):_____	

II. **The following persons or organizations are AUTHORIZED TO USE OR DISCLOSE MY PERSONAL HEALTH INFORMATION identified above:**

(ex: Physicians, specialist, family, schools, day care or other)

NAME **RELATIONSHIP**

_____

_____

_____

_____

III. Expiration Date of Authorization

This authorization will expire on (date or when–describe occurrence)_____.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Ensign Family Medicine at the address above.

The revocation will be effective only upon receipt , except (1) to the extent Ensign Family Medicine has acted in reliance on the authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wished to use the protected health information to lawfully contest a claim.

IV. I understand that treatment by Ensign Family Medicine is not conditioned on my signing this authorization, although exceptions will be made for (a) research-related treatment, (b) for treatment the purpose of which is creating protected health information for a third party, such as pre-employment physicals, and (c) except for psychotherapy notes, for health plans who condition enrollment or on an authorization requested prior to enrollment, or where payment is conditioned on authorization to use PHI to determine payment.

_____ _____

Signature of Patient (or Patient Representative*) Date

*If person signing is other than patient, state authority under which signature is made:_____