AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________ Date of Birth: ________ SSN (last 4 digits): ______

Address: ____

City: _________________________ State: ______________________ Zip:_______________

Home Phone: ___________________________ Cell Phone: ________________________

I hereby authorize (name of doctor/facility) ___________________________ to release the medical records of the above named patient to Nevada Cancer Coalition and my assigned Patient Navigator ("PN").

Purpose of Disclosure: Patient Navigator Resources

Medical Record to be Release:

☐All dates of treatment

☐For the dates of treatment from _________ to __________

Specific description of information to be disclosed:

☐Entire Medical Record (will include items to the treatment dates specified above)

☐Other (Specify): _________________________

Method of Receipt of Information: ☐Paper Copy ☐Electronic Copy (email) ☐ Secure Fax

This authorization will expire on ______________, unless requested in writing otherwise.
I understand that I may terminate this authorization at any time by sending a revocation to **pn@thrivenv.org**. I understand that upon the expiration of this authorization that no further disclose of information may be made. I understand that if I do not provide authorization, my PN may not be able to provide Services. I understand that by signing this Agreement this information may no longer be protected by federal privacy regulations.

I further understand that that the records released may contain information related to contagious disease; psychiatric or psychotherapy notes; or drug/alcohol abuse (42 CFR Part 2). I hereby waive any privilege concerning such information for the purpose of releasing it to the above authorized parties.

Signature of Patient (or Patient's Representative): _______________________________________

Date: __________________________

CLICK TO EMAIL COMPLETED FORM