MEDICAL RECORDS REQUESTS
Patient Authorization Form for Inspecting and Copying Health Information

A. I desire access to and/or copies of medical information created and maintained by North Vista Hospital. I authorize North Vista Hospital to copy and disclose to me my health information.

Patient's Name:______________________________
Date of Birth:______________________________
Social Security Number: ______________________________
Medical Record Number:______________________________

B. The information to be disclosed is: (specify the exact information to be disclosed, including dates of service):

Specify Dates of Service:______________________________
____ Complete medical records:______________________________
[OR the records marked below:]
____ History and physical:______________________________
____ Consultation reports:______________________________
____ X-ray reports:______________________________
____ Laboratory tests:______________________________
____ Discharge summary:______________________________
____ Progress Notes:______________________________
____ Photographs, videotapes, or digital or other images:______________________________
____ Billing records:______________________________
____ Other:______________________________

I understand that this information may include information relating to: acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV infection); treatment for drug or alcohol abuse; or mental or behavioral health or psychiatric care, excluding psychotherapy notes.

C. Purpose of disclosure:______________________________

D. The information should be sent to me at the following address:
Street/Apt. No./City/State/Zip Code:

____
____
____
____

F. I would like to pick up the information: Yes_____ No______

Contact Person________________ (Name and Phone#)

Account Number:	MR Number:
Patient Name:	
Admit Date:	

1409 East Lake Mead Blvd.
North Las Vegas, NV 89030
(702) 649-7711

DOB	Age	Sex	HT	WT	RM-BD	PT	SVC	FC
Allergies:								
Attending Physician Name:								

G. Unless otherwise revoked, this authorization will expire when revoked by me; I may revoke this authorization form at any time. Initials:________

I understand that te North Vista Hospital may charge a fee for the costs of copying, mailing, or other supplies associated with this request.

North Vista Hospital may deny your request to inspect and copy medical records in certain limited circumstances, which are described in separate policies. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by North Vista Hospital will review your request and the denial. The person conducting the review will not be the person who denied the request. North Vista Hospital will comply with the outcome of the review.

____
Signature of patient or patient's representative

____
Printed name of patient or patient's representative

____
Relationship to patient giving representative authority to act for patient

Date:______________________________ (Month/Day/Year)

Daytime telephone number:___________________________

Facsimile number:___________________________________

Contact Person________________ (Name and Phone#)

Account Number:	MR Number:
Patient Name:	
Admit Date:	

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Allergies:

Attending Physician Name: