Authorization for Disclosure of Medical Information

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3235 E. Warm Springs Rd.
Suite 110
Las Vegas, NV 89120
office: (702) 802-5200
Fax: (702) 802-5201

Patient's Name: _____ DOB: _____

Address: _____

City, State & Zip Code: _____

Social Security #: _____ Patient's Phone #: _____

Date of Request: _____ Date Needed: _____

❑ I authorize Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center to **release information to:**

OR

❑ I authorize Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center to **obtain information from:**

Name of Provider/Facility: _____

Address: _____

City, State & Zip Code: _____

Phone #: _____ Fax#: _____

Purpose for this request: ❑ Healthcare Treatment ❑ Insurance Coverage ❑ Personal
❑ Transfer of Care ❑ Other

Type of Records Authorized:
❑ Immunization History
❑ All medical records related to a specific illness or injury:
Specify illness/injury: _____
Date(s) of treatment: _____
❑ Treatment summary (including history/physical, laboratory tests & x-ray reports, pathology)
❑ Specific information:
❑ Procedure report ❑ History & Physical ❑ Physical Therapy ❑ X-ray reports
❑ Laboratory test results ❑ Other: _____
❑ Copy of the entire medical record, as allowed by law.

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at anytime by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information state above could be re-disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

Signature: _____ **Date:** _____