AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name **Phone Number**

Address **City** **State** **Zip Code**

Date of Birth **Social Security Number**

I hereby authorize: _____

(Doctor or Facility)

Address **City** **State** **Zip Code**

Its designee, medical records department, or equivalent, to release protected health information, including alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations, Part 2, if any; behavioral medicine services records, if any, including communications made by me to a social worker or psychologist; and any information regarding communicable diseases and infections as defined by MCLA 333.5131, if any, which includes venereal disease, tuberculosis, HIV, AIDS, and ARC, to individuals or organizations listed below, only under the conditions listed below.

Release information to: **CHAMIAN MEDICAL GROUP, PLLC**

7325 South Pecos Road Suite # 102 Las Vegas, Nevada 89120

Ph(702)982-6402 fax(702)202-0674

Please specify: ☐ Complete Medical Records

☐ Records Pertaining to:_____

This authorization can be revoked, in writing, at any time except to the extent that information has already been released or disclosed. Any authorization for release or disclosure of drug and alcohol abuse records shall end when the purpose for the release has been achieved.

This authorization will expire automatically 1 year from the date signed.

(Patient / Authorized Representative Signature) **(Relationship to Patient, if not self)** **(Date)**

(Signature of Witness) **(Date)**