**SOUTH LYON MEDICAL CENTER**
**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**Patient Privacy:** Our practice is committed to securing the privacy of your health information. Accordingly, we have posted the Notice of Privacy Practices in the reception area. You are not required to read this notice. However, we would appreciate your acknowledgement that you have been notified that this practice has such a Notice of Privacy Practices.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO A RELATIVE OR PERSONAL RESPRESENTATIVE:

I,_____ DOB:_____
(Print Patient's Name) (Patient's Date of Birth)

_____
(Address)

AUTHORIZE MY PHYSICIAN AND/OR SOUTH LYON MEDICAL CENTER TO DISCLOSE THE FOLLOWING HEALTH INFORMATION TO:

Name(s) of relative(s) or personal representative to receive information:

_____
(name) (Relationship to Patient)

_____
(name) (Relationship to Patient)

**Describe the health information that you are authorizing for disclosure. Please include type of information, any restrictions, or other information relevant to your authorization. Your health information shall include:**

☐ All Information Below ☐Lab/X-ray ☐Other
☐Office Notes ☐Hospital Records ☐ Financial/Billing
☐Restrictions, if any_____

_____

I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

This consent and authorization shall be valid as long as I am a patient of this practice, or until I revoke this consent and authorization in writing. I understand that I have the right to revoke this consent, in writing, at any time by sending a written notification to the practice's Medical Records Department at P O Box 940, Yerington, Nevada 89447.

**Expiration and Revocation:**

Expiration: This authorization will expire (complete one):

☐ On _____/_____/_____

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

_____

_____

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the office listed below. Revocation of this authorization will not affect any action we took in reliance to this authorization before we received your written notice of revocation.

**South Lyon Medical Center**
**Medical Records Department**
**P O Box 940**
**Yerington, Nevada 89447**
**775-463-2301**
**775 463-4300 Fax**

**SIGNATURE: I have read this authorization and I understand it**

_____

(Patient and /or Relative or Personal Representative (Date)

_____

(Preferred phone number)