LINCOLN COUNTY MEDICAL ASSOCIATES RHC
700-A N. Spring St. P.O. Box 1010
Caliente, Nevada 89008
Phone: (775)726-3121
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GROVER C. DILS MEDICAL CTR.
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LINCOLN COUNTY MEDICAL ASSOCIATES – ALAMO
33 Joshua Tree St, P.O. Box 548
Alamo, Nevada 89001
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

THE ORIGINAL RECORD IS THE PROPERTY OF **GROVER C. DILS MEDICAL CENTER/LCMA RHC/LCMA-ALAMO**. A MINIMUM CHARGE OF $0.60 PER PAGE WILL BE CHARGED FOR INFORMATION FOR PERSONAL USE OR ATTORNEYS. THERE IS NO CHARGE FOR INFORMATION TO BE USED BY ANOTHER MEDICAL FACILITY.

Name of Patient	DOB:
Address:	Phone:
Medical Record Number:	Social Security Number:
I hereby authorize: (Name and Address of Releasing Facility) _____	To Release Information To: (Individual Name, Facility/Organization and Address) _____

PURPOSE OF DISCLOSURE:
- ☐ Continuing Care
- ☐ Payment of Claim
- ☐ School
- ☐ Worker's Compensation
- ☐ Legal
- ☐ For Personal Use
- ☐ Other (specify)

_____
_____

All information regarding Alcohol and/or Drug Abuse or Behavioral Health will be released unless you restrict by initialing below:

_____ Do not release Alcohol and/or Drug Abuse Information

_____ Do not release Behavioral Health Information

Information To Be Released:
Between Dates of:_____ to:_____

☐ Discharge Summary	☐ X-Ray/CT/Ultrasound Report(s)	☐ Psychiatric Testing
☐ H&P Exam/ Initial Evaluation	☐ X-Ray Films/CT	☐ Transfer/Outside Information
☐ Consult	☐ Diagnostic Test Reports	☐ Completed Form
☐ Counselor/Therapist Reports	☐ Procedure Reports	☐ Exchange of Verbal Communication
☐ Progress Notes/Provider Notes	☐ Lab Reports/Pathology	☐ HIV related information (AIDS relates testing)
☐ Orders	☐ Correspondence	
☐ Other: (specify)_____		
_____		

ACKNOWLEDGEMENT OF UNDERSTANDING

- I understand the expiration date of this authorization is effective for _____ or 1 year from today's date, whichever is sooner.
- I understand I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drugs abuse information is subject to revocation at anytime except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand that **GCDMC/LCMA RHC/LCMA-ALAMO** may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand I will receive a copy of this form after I have signed it.
- I understand a photocopy or fax of this form is the same as the original.
- I agree to hold **GCDMC/LCMA RHC/LCMA-ALAMO** harmless from any and all liability that may arise by complying to this authorization.

_____ _____ _____
Signature of Patient, Parent of Minor, or Personal Representative | Relationship | Date

_____ _____
Witness | Date

#of pages_____/Amount Due: $_____

To the party receiving this information; this information has been disclosed to you from confidential records. You are prohibited from making any further disclosures of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law.