Authorization to Obtain Protected Health Information

Patient's Name: ____

Date of Birth: _________________________ Phone: _____________________________

Carson Medical Group Physician: ____

I, ____

Herby authorize Carson Medical Group to obtain the following protected health information from:

Person or Entity: ____

Fax: _______________________________________

Mail: ____

____

____

Information to be disclosed: __ Medical Records __Other: __________________________

____

____

I also consent to the release and any and all information regarding alcohol, drug abuse, psychiatric/mental health, communicable disease, hepatitis, AIDS and HIV.

X____ X______________________________

Patient/Guardian Signature Date

Rev 01/13/2016 – CMG/CMG Forms/HIPAA Obtain Form

Please verify receipt by calling the telephone number checked below. Please return to the sender checked below:

☐ **Family Practice**
1200 Mountain St
Carson City, NV 89703
Phone 775.882.1324
Fax 775.882.3859

☐ **Pediatrics – Carson**
1475 Medical Pkwy
Carson City, NV 89703
Phone 775.885.2229
Fax 775.882.5045

☐ **OB/GYN & Pediatrics- Minden**
925 Ironwood Dr, Ste 2111
Phone 775.782.5330
Fax 775.782.5954

☐ **Ear, Nose & Throat**
1200 Mountain St
Carson City, NV 89703
Phone 775.884.3687
Fax 775.884.3458

☐ **OB/GYN- Carson**
1475 Medical Pkwy
Carson City, NV 89703
Phone 775.883.3636
Fax 775.882.2382

For office staff only:

Date received (initial & date)

Patient/Guardian Identification

Disclaimer:
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