



**Saint Mary's
Primary Care Plus**
A member of CHW

SOUTH VIRGINIA
8040 S. Virginia Street
Suite 4
Reno, Nevada 89511
(775) 852-3636
(775) 852-3639 fax

**AUTHORIZATION FOR DISCLOSURE OF
PATIENT-IDENTIFIABLE HEALTH INFORMATION**

ADDRESSOGRAPH

Please print clearly

Patient Name _____
Patient Address _____

Phone # (____) _____
Date of Birth _____
Social Security # _____
Medical Record # _____

The SMHN entity(ies) involved in this request is/are:

- Saint Mary's Urgent Care – Galena
- Saint Mary's Urgent Care – S. McCarran
- Saint Mary's Urgent Care – S. Virginia
- Saint Mary's Urgent Care – Mae Anne
- Saint Mary's Urgent Care – Spanish Springs
- Saint Mary's Medical Group – Galena
- Saint Mary's Medical Group – S. McCarran
- Saint Mary's Medical Group – S. Virginia.
- Saint Mary's Medical Group – Mae Anne

1. I hereby authorize SMHN

- _____ To disclose the following information of the above-designated patient.
- _____ To allow review of the original medical record of the above-designated patient.

2. Information to be disclosed and timeframe

- _____ Complete health records _____/_____/_____ to _____/_____/_____
- _____ History and physical exam _____/_____/_____ to _____/_____/_____
- _____ Consultation reports _____/_____/_____ to _____/_____/_____
- _____ X-ray and imaging reports _____/_____/_____ to _____/_____/_____
- _____ X-ray films _____/_____/_____ to _____/_____/_____
- _____ Laboratory test results _____/_____/_____ to _____/_____/_____
- _____ Discharge summary _____/_____/_____ to _____/_____/_____
- _____ Emergency department record _____/_____/_____ to _____/_____/_____

_____ Other (This shall not included psychotherapy notes. See form #61644, Authorization for Disclosure of Psychotherapy Notes) please specify:
