1 Breakthrough Way
Las Vegas, NV 89135
Phone: (702) 732-1493
Fax: (702) 732-1080

CURE 4 THE KIDS
FOUNDATION
A Division of Roseman University of Health Sciences

4425 S. Pecos Road Ste 6
Las Vegas, NV 89121
Phone: (702) 333-7000
Fax: (702) 537-8787

Authorization to Release Protected Health Information

I authorize Cure 4 The Kids Foundation to disclose protected health information (PHI) on the following patient:

Name: _____ **Date of birth:** _____

Purpose of the disclosure: ☐ Medical Care ☐ Insurance ☐ Personal ☐ Attorney ☐ Other: _____

Documents to be released (please be specific):

☐ Progress Notes ☐ Laboratory Results ☐ Discharge Summary

☐ Radiology Reports ☐ Consultation Reports ☐ Operative Reports

☐ X-Ray Films or Other Images ☐ Records From Other Facilities

☐ Entire Health Record (including but not limited to information regarding medical treatment, insurance, demographics, referral documents, records from other facilities, etc.)

☐ Other (please specify) _____

If applicable, I give specific authorization to disclose the following information:

☐ HIV Information ☐ Child/Domestic Abuse History

☐ Psychiatric/Mental health records ☐ Addictive Behaviors

☐ Genetics Labs / Consult Notes ☐ Communicable/Sexually Transmitted Diseases

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission cannot be retracted. I may revoke this authorization by notifying Cure 4 the Kids Foundation in writing. My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Nevada privacy regulations.

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

Printed Name of Person Requesting: _____ **Phone Number:** (_____) _____- _____

Relationship to Patient: ☐ Patient ☐ Parent ☐ Guardian ☐ Other _____

Authorizing Signature: _____ **Date of Signature:** ____/____/_____

**** Provide mark the box to release patient medical records ****

☐ **Fax records to:** Pediatric Orthopedics of Nevada **Fax Number:** (725) - 240 - 5310

☐ **Fax records to:** Other Provider:_____ **Fax Number:** _____

UNLESS I SPECIFY ANOTHER DATE: ___/___/___

THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM THE DATE SIGNED

UNLESS I SPECIFY ANOTHER DATE: _____/_____/_____