AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:	Birth Date:	SS Number:
	Address:	

Release Records To:	**MEDTYME EMERGENCY MEDICAL RELIEF ASSOCIATION** 6628 Sky Pointe Dr., Suite 100, Las Vegas, NV 89131 · (702) 586-4MED (4633)

Purpose of Disclosure: ______ For General or Insurance Purposes
______ At the Request of the Patient
______ Assist Patient with Medical or Financial Matters
______ Other, Please Explain ____

I Authorize MedTyme Relief Association to use and disclose the protected health information ("PHI") identified below.

Description of Information to be Used or Disclosed

Dates of Treatment:	**Type of Treatment:** ☐ Inpatient ☐ Emergency Room ☐ Outpatient ☐ Home Health

Choose From the Following:

☐ Admission History/Physical ☐ Outpatient Records ☐ Consultation
☐ Discharge Summary ☐ Rehabilitation Evaluation ☐ Other

I understand that:

1. I understand that I may revoke this authorization in writing at any time except to the extent that MedTyme or its employees or agents have acted upon this authorization.

2. I understand that if the organization authorized to receive the information is not a health care provider and if such information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations, but may be protected under Nevada law.

3. It is necessary for MedTyme or a provider agency to verify your medical needs to determined your eligibility or if you meet the essential requirements. When you sign this authorization, you are giving MedTyme or a provider agency your permission to contact your physician, medical facility, or other health care provider and obtain copies of your health information as indicated below. Your signature is required on this authorization form to determined your edibility for services.

4. MedTyme or a provider agency, as receiver of this information, will protect your personal health information in accordance with federal and state privacy regulations. If you authorize release of your health information to other parties, it may no longer be protected by privacy regulations.

5. I understand that there will be a charge for copying records if applicable.

I have read and understood this authorization. I hereby authorize the release, use, and disclosure of the above-requested protected medical information about me. I understand this information is use solely to assistance me in my time of need.

____ ____
Signature of Patient: Signature of Patient's Authorized Representative:

Date: ______________ Contact Telephone Number: (1) ____________________ (2) ____________________

Description of Representative's Authority to Act on behalf of Patient: ____________________________________

☐ *Spouse* ☐ *Domestic Partner* ☐ *Family Member* ☐ *Relative* ☐ *Guardian* ☐ *Custodian* ☐ *Friend* ☐ *Notary Public* ☐ *Legal* ☐ *Other*