AUTHORIZATION

This Authorization authorizes the release of Protected Health Information pursuant to 45 CFR Parts 160 and 164.

1. The undersigned authorizes _____,
   and any of its employees or business associates, to release the following information: (describe specifically)_____

2. The information may be disclosed to _____(insert name or other specific identification of the persons or entities to which the disclosure will be made)

3. The disclosure may be made for the following purpose_____
   (describe specifically. If disclosure is at patient's request, "Patient request" will suffice)

4. This authorization will expire on (date) _____. (or when—describe occurrence).

5. I acknowledge: (i) that I have the right to revoke the authorization at any time, and (ii) that I understand that once the information is disclosed, federal privacy law may no longer protect it.

6. I may revoke this authorization only in a writing sent by certified mail to (the Provider) at the address below. The revocation will be effective only upon receipt, except (1) to the extent (the Provider) has acted in reliance on the authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use to the protected health information to lawfully contest a claim.

7. I understand that treatment by (the Provider) is not conditioned on my signing this authorization, although exceptions will be made for (a) research-related treatment, (b) for treatment the purpose of which is creating protected health information for a third party, such as pre-employment physicals, and (c) except for psychotherapy notes, for health plans who condition enrollment or on an authorization requested prior to enrollment, or where payment is conditioned on an authorization to use PHI to determine payment.

Patient Name Printed_____Patient Signature: _____

Or

Parent/Guardian Signature:_____Relationship to Patient: _____

Date: _____

(The patient must be given a copy of the authorization.)

3602 E. Sunset Rd. Suite 100 Las Vegas, NV 89120 Phone: 702-932-4308 Fax 702-837-8930

Comprehensive Therapy Centers

Medical records are being picked up on patient _____ by _____
(Patient Name) (Person Receiving Records)

The patient will not be charged for these records. Should the records be requested again a $.60 per page fee will apply.

Records that are being sent include the following:

_____

_____

_____

_____ _____
Patient / Guardian Signature Date

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