CUMULUS HOSPITAL
123 Neon Way, Las Vegas, NV 89101 Authorization Form

I. PATIENT INFORMATION

Full Name: _____ Date of Birth (MM/DD/YYYY): _____Gender:_____Address:_____ _____ City: _____ State: _____ Zip Code: _____Phone Number:_____Email: _____

II. AUTHORIZATION DETAILS

I hereby authorize Cumulus Hospital to disclose/release the following information to the individual or entity named below:

Authorized Recipient Name/Entity: _____Relationship to Patient: _____Address/Contact Info of Recipient: _____

Purpose of Disclosure: [ ] Medical Care Coordination [ ] Insurance Review [ ] Personal Use [ ] Other: _____

Information to be Disclosed: [ ] Entire Medical Record [ ] Lab Results [ ] Imaging/Radiology Reports [ ] Billing Records [ ] Other: _____

III. EXPIRATION AND REVOCATION

This authorization shall remain in effect until: [ ] Date: (MM/DD/YYYY) _____ [ ] Until the following event: _____

I understand that I have the right to revoke this authorization at any time by providing written notice to Cumulus Hospital.

IV. SIGNATURE

Patient/Guardian Signature: _____ Date: _____

V. OFFICE USE ONLY

Authorization Received Date: _____ Processed by: _____ Reference #: _____

Form ID: REG-003