CUMULUS HOSPITAL
123 Neon Way, Las Vegas, NV 89101 Medical Records Release Form

## I. PATIENT INFORMATION

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

## II. RELEASE OF INFORMATION

I hereby authorize the release of my medical records to the following entity:

Recipient Name/Facility: _____
Address: _____ City: _____ State: _____ Zip Code: _____ Phone Number: _____ Fax: _____

## III. RECORDS TO BE RELEASED

Please check all that apply: [ ] Entire Medical Record (All dates) [ ] Specific Dates of Service: From _____ To _____ [ ] Lab Reports / Diagnostic Imaging (MRI, X-Ray, Ultrasound) [ ] Billing / Insurance Records [ ] Other: _____

## IV. PURPOSE OF RELEASE

[ ] Continuity of Care/Transfer of Care [ ] Insurance Application/Review [ ] Personal/Legal Use [ ] Other: _____

## V. PATIENT ACKNOWLEDGMENT

I understand that I have the right to revoke this authorization in writing at any time. I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations (HIPAA).

Patient/Guardian Signature: _____ Date: _____

## VI. OFFICE USE ONLY

Request Received Date: _____ Processed by: _____
Method of Release: [ ] Email [ ] Secure Portal [ ] Physical Copy Reference #: _____

Form ID: REG-004