CULINARY Health Center

Authorization for Release of Protected Health Information

Patients have the right to request to view or get a copy of their Protected Health Information (PHI) or have the Culinary Health Center* (CHC) send their PHI to another person or organization. Please note that patients may be required to pay a reasonable, cost-based fee for copying (including the cost of supplies and labor) and/or postage. Patients will be notified in advance if a fee is required. To make any of these requests, please complete and send this form:

- ❑ **In person:** Hand in at the CHC
- ❑ **By mail to:** Culinary Health Center
  Attn: Medical Records
  650 N. Nellis Blvd.
  Las Vegas, NV 89110
- ❑ **By fax to:** 844-633-9997
- ❑ **By email to:** culinaryhc@dmrs.net
  Please note: If you choose to email personal information to the CHC, we can't ensure it will remain private or secure until it's received.

For help: Call **702-790-8000** and ask for the Patient Experience Team or the HIPAA Privacy Team.

Check One:	❑ I am the participant/member. (I get insurance coverage through my job.) ***Fill out Section 1.*** ❑ I am a dependent (I get coverage through the participant/member who is my family) ***Fill out Sections 1 & 2.***

Section 1: Participant (Member) Information

Last name:	First name:		Middle initial:	
Date of birth: _____/_____/_____	SS #:		Phone #:	
Street:	Apt. #:	City:	State:	Zip:

Section 2: Dependent Information

Full name:	Relationship to Participant/Member:			
Date of birth: _____/_____/_____	Age:	Phone #:		
Street:	Apt. #:	City:	State:	Zip:

Check One:	❑ I am requesting to view and/or get a copy of my or my dependent's PHI. ***Fill out Section 3.*** ❑ I am requesting a copy of my or my dependent's PHI be sent to another person or entity. ***Fill out Section 4.***

Section 3: I am requesting to view and/or get a copy of my or my dependent's PHI.

I want the CHC to release the following information to me:

_____

_____

_____

❑ Include all information relating to alcohol, drug or substance abuse, genetic testing, sexually transmitted diseases, HIV/AIDS, and behavioral or mental health services (excludes psychotherapy notes).

Choose method of delivery:

❑ Email (provide email address): _____

❑ Mail (provide address): _____

❑ Pick up at the Culinary Health Center (We will call you when the information is ready to be picked up.)
Who will be picking up the information?: _____
Relationship to patient? _____

❑ Inspect at the Culinary Health Center (You'll need to call **702-790-8000** to schedule a date and time.)

Section 4: I am requesting a copy of my or my dependent's PHI be sent to someone else.

What is the purpose of this authorization? (Check one):

❑ At my request ❑ For a different purpose: _____

I want the Culinary Health Center to discuss and/or release

❑ my PHI or ❑ my dependent's PHI to the following person or organization:

Person/organization: _____ Phone #: _____

Relationship to me (my sister, doctor, lawyer, etc.): _____

Choose method of delivery:

❑ Email (provide email address): _____

❑ Mail (provide address): _____

I want the CHC to discuss and/or release the following information to the person or organization named above:

_____

_____

_____

❑ Include all information relating to alcohol, drug or substance abuse, genetic testing, sexually transmitted diseases, HIV/AIDS, and behavioral or mental health services (excludes psychotherapy notes).

I want this Authorization to expire (Check one):

❑ Not until I revoke ❑ On this date (Please specify): _____

❑ When the following event occurs: _____

If I do not check a box, this authorization will expire in one year.

I authorize the use or disclosure of my health information as previously described. I have read and understand the contents of this form. I understand that the Culinary Health Center cannot control information after it is released. I understand that this request may include any reports, correspondence, test results, diagnosis, or medical procedures. I understand that I can revoke (cancel) this Authorization at any time by notifying the Culinary Health Center's Privacy Team in writing, but revoking will not affect information already released. If I revoke this Authorization, additional information will not be released, except where permitted or required by law.

I am signing this form voluntarily. If I do not sign this Authorization, my ability to obtain treatment, payment, enrollment, or eligibility for benefits with UNITE HERE HEALTH and the Culinary Health Center doesn't change.

By signing and dating this form, I am allowing the Culinary Health Center to share my and my dependent's health information with the person or organization named previously.

Section 5: Required Signature and Date

Signature of the person authorizing release of PHI:	Date:
Print name:	Relationship to Participant/Member:

Section 6: For CHC Use Only	
Received by:	Date recieved:
❑ Copy mailed on:	❑ Copy given to individual on:

*For purposes of this Authorization, all references to Culinary Health Center or CHC include the Neighborhood Health Center, LLC.