CJ Medical Center
KEEPING YOU WELL

Authorization for Release of Information-Protected Health Information (PHI)

Patient Name	
DOB	
Address	Address City State Zip Code
Phone No.	
Social Security No.	

I hereby authorize

Name	
Phone No.	
Fax Number	

To release my medical record as indicated below to:
Attention: Medical Records
CJ MEDICAL CENTER
cjmcenter.adm@cj-mcenter.com
Telephone:(702) 551-4608 Fax Number: 725.215.9309

Information to be released	Date
History of Physical Exam	Date
Progress Notes	Date
Lab Reports	Date
X-ray Reports	Date
Other (Specify)	Date

CJ Medical Center
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ENTIRE MEDICAL RECORD	DATE

Purpose of Disclosure

	Changing Primary Care Provider
	Insurance
	Consultation / Second Opinion
	Legal
	Moving
	Other

I specifically authorize the Release of Information relating to:

	Substance Abuse (including alcohol/drug)
	Mental Health (including Psychotherapy notes)
	HIV-related information (AIDS-related testing)

Click on the link to get aware of the use of this form;
https://docs.google.com/document/d/1nLbrE0wV4gk9poa9hIhDyE7r1_6wv1bgvHNsrrDrSTE/edit

Signature of Patient or Legal Guardian:_____

Date: _____