

Authorization to Obtain Protected Health Information

	Phone:	
Carson Medical Group Physic	cian:	
l,		
Hereby authorize Carson Me from:	edical Group to obtain the followin	ng protected health informat
Person or Entity:		
Fax:		
Mail:		
Unless specified otherwise in	please supply the recent 2 years of	
Medical Records requested:	•	i medicai records.
Miculcal Necolus requesteu.		
I also consent to the release and	d any and all information regarding a	lcohol, drug abuse,
I also consent to the release and		lcohol, drug abuse,
I also consent to the release and psychiatric/mental health, com	d any and all information regarding a municable disease, hepatitis, AIDS ar	lcohol, drug abuse, nd HIV.
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I also consent to the release and psychiatric/mental health, com X Patient/Guardian Signature rerify receipt by calling the telephology and processing the consensus of the co	d any and all information regarding a municable disease, hepatitis, AIDS ar X Da one number checked below. Please returns of the company of	te Rev 11/23/2020 - CMG/CMG FORMS/HIPAAG urn to the sender checked below: Pediatrics Carson
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I also consent to the release and psychiatric/mental health, com X Patient/Guardian Signature erify receipt by calling the telephore Family Practice Carson 1200 Mountain St Carson City, NV 89703 Minden 925 Ironwood Dr, Ste 2111 Phone 775.882.1324	d any and all information regarding a municable disease, hepatitis, AIDS are X E Da one number checked below. Please retuing OB/GYN Carson 1475 Medical Pkwy Carson City, NV 89703 Minden 925 Ironwood Dr, Ste 2111 Reno	te Rev 11/23/2020 - CMG/CMG FORTM/HIPAAG urn to the sender checked below: Pediatrics Carson 1475 Medical Pkwy Carson City, NV 89703 Minden 925 Ironwood Dr, Ste 2111 Reno
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