



**Autorizacion Para Obtener Informacion De Salud Protegida**

Nombre del paciente: \_\_\_\_\_

Fecha de nacimiento: \_\_\_\_\_ Numero de telefono: \_\_\_\_\_

Nombre del Dr(a) de Carson Medical Group: \_\_\_\_\_

Yo, \_\_\_\_\_

Autorizo a Carson Medical Group a obtener la siguiente informacion de salud protegida de:

Persona o Entidad: \_\_\_\_\_

Fax: \_\_\_\_\_

Correo: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*A menos que se especifique lo contrario, porfavor suministre los ultimos 2 anos de registros medicos. Registros Medicos solicitados:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tambien doy mi consentimiento para la divulgacion y cualquier informacion sobre alcohol, abuso de drogas, salud psiquiatrica/mental, enfermedades transmitibles, hepatitis, sida y VIH.**

X \_\_\_\_\_  
Firma del paciente/Tutor

X \_\_\_\_\_  
Fecha

Please verify receipt by calling the telephone number checked below. Please return to the sender checked below:

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1475 Medical Pkwy  
Carson City, NV 89703  
**Minden**  
925 Ironwood Dr, Ste 2111  
**Reno**  
9400 Double R Blvd  
**Phone** 775.883.3636  
**Fax** 775.882.2382

**Pediatrics Carson**  
1475 Medical Pkwy  
Carson City, NV 89703  
**Minden**  
925 Ironwood Dr, Ste 2111  
**Reno**  
9400 Double R Blvd  
**Phone** 775.885.2229  
**Fax** 775.882.5045

**Ear, Nose & Throat**  
1946 Old Hot Springs Rd  
Carson City, NV 89706  
**Phone** 775.884.3687  
**Fax** 775.884.3458

**For office staff only:**  
Date received (initial & date)  
Patient/Guardian  
Identification

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