Carson Medical Group

Authorization to Obtain Protected Health Information

Patient's Name: _____

Date of Birth: _____ Phone: _____

Carson Medical Group Physician: _____

I, _____

Hereby authorize Carson Medical Group to obtain the following protected health information from:

Person or Entity: _____

Fax: _____

Mail: _____

_____

_____

Unless specified otherwise, please supply the recent 2 years of medical records.
Medical Records requested:

_____

_____

_____

I also consent to the release and any and all information regarding alcohol, drug abuse, psychiatric/mental health, communicable disease, hepatitis, AIDS and HIV.

X_____ X_____

Patient/Guardian Signature Date

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

☐ **Family Practice**
Carson
1946 Old Hot Springs Rd
Carson City, NV 89706
Minden
925 Ironwood Dr, Ste 2111
Reno
9400 Double R Blvd
Phone 775.882.1324
Fax 775.882.3859

☐ **OB/GYN**
Carson
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

For office staff only:

Date received (initial & date)

Patient/Guardian Identification

Disclaimer:
The information contained in this facsimile message is intended for the sole confidential use of the designated recipients and may contain confidential information. If you have received this information in error, any review, dissemination, distribution or copying of this information is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us by mail or if electronic, reroute back to the sender. Thank you.