Carson Medical Group

Autorizacion Para Obtener Informacion De Salud Protegida

Nombre del paciente: _____

Fecha de nacimiento: _____ Numero de telefono: _____

Nomber del Dr(a) de Carson Medical Group: _____

Yo, _____

Autirizo 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_____ X_____

Firma del paciente/Tutor Fecha

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:
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