SOUTHERN NEVADA FAMILY MEDICINE
Board Certified in Family

*** STAT ***

*** STAT ***

Dr. Amir K. Nicknam, M.D.
Meagan Hill APRN
Ron Ludwiszewski, PA-C
Yaw-Jong Tsai PA-C

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH:_____/_____/_____

PREVIOUS NAME: _____ SNN: _____-_____-_____ (optional)

I request and authorize _____ to release my healthcare information to:

☐ SOUTHERN NEVADA FAMILY MEDICINE
1765 Village Center Circle Suite 101
Las Vegas, NV 89134
P: (702) 733-6622
F: (877) 361-1165

☐ SOUTHERN NEVADA OCCUPATIONAL HEALTH CENTER
4060 N Martin Luther King Blvd Suite 101A
N Las Vegas, NV 89032
P: (702) 380-1712
F: (877) 361-1165

This request and authorization applies to:

☐ ALL healthcare information
☐ Healthcare information related to the following treatment, condition, or dates:
_____
_____
_____
☐ Other: _____

DEFINITION: Sexually transmitted disease (STD) as defined by law, RCW 70.24 ET SEQ. includes herpes, herpes simplex, human papilloma virus, wart, genital warts, condyloma. Chlamydia, non- specific urethritis, syphilis, VDRL, cancroid, lymphogranuloma. Venereum, human immunodeficiency virus (HIV), acquired Immune Deficiency Syndrome (AIDS), and gonorrhea.

☐ YES ☐ NO I Authorize the release of my STD results, HIV/ AIDS testing, whether negative or positive to SNOHC/SNFM. I understand that they will be notified that I must give specific written permission before disclosure of the test results to anyone.

☐ YES ☐ NO I authorize the release of any records regarding drug, alcohol or mental health treatment to SNOHC/ SNFM

PRINT PATIENT'S NAME PATIENT'S SIGNATURE TODAY'S DATE