Dr. Samantha Schneider
Pacific Crest Dermatology
5050 Vista Blvd, #102
Sparks, NV 89436
775-451-DERM (3376)

Date: _____
Patient Name: _____
Patient DOB: _____

I hereby authorize the release of my medical records from:

☐ Pacific Crest Dermatology
5050 Vista Blvd, #102
Sparks, NV 89436
Phone: 775-451-3376
Fax: 775-490-0186

☐ Name: .....
Address: .....
City: _____ State: ____ Zip: _____
Phone#: ..... Fax#: .....

I authorize the release of the following records:

- ☐ My complete medical record which may include, but is not limited to, history and physical, examination notes, diagnostic studies, laboratory test results, diagnoses, treatment plans, and all other records pertaining to any medical services provided to me at any time to the present date; **OR**
- ☐ My complete medical record for the dates of _____ through _____. (For example: January 1, 2014 to December 31, 2015).
- ☐ I wish to exclude the following items from being released: (For example: lab results , etc.)

  _____
  _____
  _____

- ☐ Please only include the following:
  - ☐ Visit Notes
  - ☐ Laboratory Work, Including Pathology Reports
  - ☐ Patient photos
  - ☐ Billing Information
  - ☐ Other: .....
  - ☐ Date Range: _____
  - ☐ __

Please transfer copies of the records to:

☐ Pacific Crest Dermatology
5050 Vista Blvd, #102
Sparks, NV 89436
Phone: 775-451-3376
Fax: 775-490-0186

☐ Name: .....
Address: .....
City: _____ State: ____ Zip: _____
Phone#: ..... Fax#: .....

I understand that my complete medical record may include information regarding communicable diseases including HIV/AIDS, treatment for alcohol or drug abuse or treatment of mental health issues.

I understand that pursuant to NRS 629.061(4) that I may be charged a reasonable fee for copies of my medical record, not to exceed $.60 per page and that that actual costs may be charged for reproducing radiology films.

This authorization is valid from the date of my signature below and shall expire within twelve (12) months from the date the authorization is valid unless I have specified an earlier date below:
This authorization is valid until _____.

I understand that I may revoke this authorization at any time by providing written notice to PCD I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions, taken prior to my revocation. I understand that the information disclosed may be subject to re-disclosure by the persons receiving it and would no longer be protected by federal privacy regulations.

I understand that my ability to obtain treatment may not be conditional upon my refusal to sign this authorization.

_____
Printed Name

_____
Patient/Responsible
Party Signature

_____
Date