Nevada State Board of Podiatry

6170 Mae Anne Avenue, Suite 1, Reno, NV 89523
Podiatry.nv.gov Phone 775-746-9424

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

You are hereby authorized to give to the Nevada State Board of Podiatry, or any representative thereof, any and all information which may be requested regarding _____'s physical condition and treatment rendered, therefore, and to allow them or any physician appointed by them, to examine any x-ray pictures taken and to inspect, review and make copies including photo static copies, of all medical records which you have regarding the patient's condition or treatment, including, but not limited to any and all blood, breath and/or urine test results, communicable disease information, including information about sexually transmitted disease(s), including HIV and AIDS, mental health treatments and/or drug and/or alcohol abuse. I further authorize the Board of Podiatry to be allowed to speak with any of my providers, in any manner, regarding my condition or treatment.

I intend that this Authorization shall be continuing in nature. If information responsive to this Authorization is created, learned or discovered at any time in the future, either you or another party must produce such information to the requestor at that time.

I acknowledge that I have the right to revoke this Authorization at any time, and that I understand that, once the information is disclosed, it may no longer be protected by the regulations imposed by 45CFR § 164.508. I further acknowledge that this Authorization may be revoked only in writing, sent via certified mail, to the Provider named above and that said revocation will be effective only upon receipt of the written request by said Provider.

This Authorization is executed and served in compliance with the Federal Regulations governing the release of private health information as outlined under 45 CFR § 164.508.

A photo static copy of this Authorization shall be considered as effective and valid as the original.

DATED: _____ , 20___

_____
Signature of Patient or Guardian

D.O.B.: ___/__/_____

S.S.N.: ____-____-_____