



DR. SHANE D. DRAPER
DR. QUINN D. LINDSTROM
Foot & Ankle Specialists
SUE WINDOUS,
FNP-BC

Authorization to Use or Disclose Health Information

Patient Name: _____ Health Record # _____

Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. Dr. Shane Draper is authorized to make the disclosure
3. The type of information to be used or disclosed is as follows (indicate your choice below and include other information where indicated.)
 - a. entire medical record
 - b. laboratory results (please describe the dates or types of laboratory tests you would like to disclose) _____
 - c. x-ray and imaging reports (please describe the dates or types of x-ray or images you would like to disclose) _____
 - d. other (please describe) _____
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. The information identified above may be used by or disclosed to the following individuals or organizations:
Name: Ruby Vista Medical Dr. Shane Draper, Dr. Quinn Lindstrom, Sue Windous FNP-BC
Address: 2078 Idaho Street Elko, Nevada 89801
Phone #: (775) 738-1100 Fax #: 775-738-1101
6. This information for which I'm authorizing disclosure will be used for the following purpose:
 - a. my personal records
 - b. sharing with other health care providers as needed
 - c. other (please describe) _____
7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Ruby Vista Medical. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
8. This authorization will NEVER EXPIRE. If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.
9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal representative: _____ Date: _____

If signed by level representative, relative to patient: _____

Signature of witness: _____ Date: _____

775.738.1100

2078 Idaho Street | Elko, Nevada 89801