TO PATIENTS TREATED IN ALL UNITS OF NYE REGIONAL MEDICAL CENTER

As the duly appointed and acting CUSTODIANS OF THE MEDICAL RECORDS, we have been given the responsiblitly for the proper disbursement of patient medical records. Our responsiblity requires that we catalogue to the best of our ability medical records, which document the treatment provided by physicians and all caregivers at Nye Regional Medical Center. **If you or your new medical provider have received your medical records, *then do not respond to this request.***

To determine if we have your records, Patients can make an inquiry no later than **May 31, 2019 as follows:**

Calling and leaving a message at: 310-703-7963
Writing to: Nye Regional Medical Center Records
P.O. BOX 647, Tonopah, NV 89049
Emailing to: NRMCrecords@thepcos.com

Your request must include: **your full name, your date of birth, a daytime contact telephone number, the approximate last date of service, and your email address should you wish to be contacted by email. It will also help us if you tell us which unit(s) of NRMC where you were treated at.** Upon receipt of your request we will determine if we have your medical record. Once we release your record to you we will not maintain any other copies of your record.

If and only if we have your medical record we will send you a release form to execute. ***A medical records release form must be completed before we can send the medical record* to the patient or their current physcian.** We will also have medical records release forms available at locations **to be announced** in Tonopah, Round Mountain and other communities. A form can also be downloaded at www.thepcos.com.

All patient files in the possession of the estate after July 1, 2019 will be destroyed and the Trustee will not be responsible for any patient records at that time.

Inquiries, questions, or comments should be sent to our attention at the addresses illustrated above or by calling our voice mail: 310-703-7963.

MEDICAL RECORDS RELEASE FORM

PATIENT ACKNOWLEDGEMENT and MEDICAL RECORDS RELEASE FORM
RE: ESTATE OF PRIMECARE NEVADA INC., DBA NYE REGIONAL MEDICAL CENTER,
BANKRUPTCY CASE: BK-S-13-20348-MKN

SECTION 1: PATIENT INFORMATION: (REQUIRED)

PATIENT LAST NAME | PATIENT FIRST NAME | PATIENT DATE OF BIRTH

STREET ADDRESS | APT | CITY | STATE | ZIP

PATIENT PHONE NUMBER

APPROX. DATE OF SERVICE

I WAS TREATED IN/AT (CHECK ALL THAT APPLY):

☐ EMERGENCY ROOM ☐ HOSPITAL IN PATIENT

☐ LABORATORY ☐ RADIOLOGY ☐ CLINIC

SECTION 2: RELEASE OPTIONS: (SELECT ONE)

○ **OPTION A: RELEASE TO DOCTOR**

I wish to have my patient information/file sent to the doctor (cited below). I hereby authorize the Chapter 7 Trustee for the case referenced above and Seelig & Cussigh HCO, LLC to release my complete patient medical record, which includes some or all of the following information on myself: copies of all medical exams, admission/discharge summaries, copies of lab/x-ray reports and information concerning any evaluation or treatment for psychiatric, alcohol and drug disorders. This release includes all information from the date of first treatment. I understand that the Trustee is releasing to the physician cited below the complete patient medical record and that the Trustee will upon release not maintain a copy of the record or any of its contents. Please release this information to:

DOCTOR/MEDICAL GROUP NAME | OFFICE PHONE NUMBER

STREET ADDRESS | SUITE | CITY | STATE | ZIP

○ **OPTION B: PICK-UP IN PERSON**

I will pick-up my patient information/file at at the Hospital at a scheduled time convenient to the former patient and the Custodian of records. We will contact you to tell you when your information is available. I understand that the Trustee is releasing to the person (cited above) the complete patient medical record and that the Trustee will upon release not maintain a copy of the record or any of its contents.

○ **OPTION C: RELEASE TO ME**

I wish to have my patient information/file sent to me. I understand that the Trustee is releasing to the person (cited above) the complete patient medical record and that the Trustee will upon release not maintain a copy of the record or any of its contents.

SEELIG & CUSSIGH, HCO, LLC | Custodian of Medical Records: NYE Regional Medical Center
PHONE: 310-703-7963 • FAX: 855-875-9870

MEDICAL RECORDS RELEASE FORM

PATIENT ACKNOWLEDGEMENT and MEDICAL RECORDS RELEASE FORM
RE: ESTATE OF PRIMECARE NEVADA INC., DBA NYE REGIONAL MEDICAL CENTER,
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SECTION 3: TERMS & CONDITIONS (PRINT & SIGN)

This release shall remain valid until you notify THE CUSTODIAN, in writing, that this release has been revoked, but in no event longer than one (1) year after the date appearing below. Although we, the CUSTODIAN, may have records with many years medical record for many years of treatments, we will unless otherwise notified send you what is requested by new caregivers, that being the pages of the medical record for the last 2-3 years of medical treatment.

I have been informed and advised of my right to receive a copy of this release. I hereby consent to the release of any and all confidential records as described under Options 1), 2) or 3), as noted above. I understand that I have the right to take back ("revoke") this authorization at any time in writing, except to the extent that you have already acted based upon my permission. I may revoke this authorization, by providing a written request to the address found above.

I understand that a signed copy of the release must be provided to me and affirm that, in fact, I have been provided with a copy of same. I understand: (1) that my refusal to authorize disclosure of the personal medical information sought herein will have no effect on my eligibility or for receipt of healthcare services I may either receive now or require in the future; and (2) that there is the potential that any information disclosed pursuant to this authorization could be subject to re-disclosures by the recipient without the protections/requirements of the Health Insurance Portability and Accountability Act (HIPPA), see 45 C.F.R.

PATIENT (RESPONSIBLE PERSON) SIGNATURE ______________________ DATE ______________

SECTION 4: DELIVERY METHOD (SELECT ONE)

For all optons you must either: a.) fax this RELEASE FORM to 855-875-9870 or b.) mail this RELEASE FORM to the address found below.

BY FAX:

ATTN: SEELIG & CUSSIGH, HCO, LLC
(855) 875-9870

OR

BY MAIL:

SEELIG & CUSSIGH, HCO, LLC
Custodian of Medical Records:
NYE Regional Medical Center
P.O. BOX 647
TONOPAH, NV 89049