NEVADA CENTRAL CANCER REGISTRY

4126 Technology Way, Suite 200, Carson City, NV, 89706 Phone: 775-684-5968

REQUEST FOR INFORMATION FORM

REQUESTOR INFORMATION

Name of person requesting information:

Address:

City:	State:	Zip:	Phone:

Relationship to patient:

☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Health care provider ☐ Health care facility ☐ Dept. of Labor
☐ Dept. of Justice ☐ Other (specify) _____

A photocopy of the requestor's identification (ID) must be enclosed with the request.

Reason information requested: ☐ Cancer verification ☐ File a claim

☐ Other: _____

The confidentiality of a cancer record is protected under NRS 457 and NAC 457. Consent is required before disclosure of <u>any</u> information. Please indicate one of the consent types below and enclose the document listed below with your request.

☐ Direct consent from patient

☐ Consent from health care provider/facility that diagnosed or treated the patient

☐ Power of attorney (certified copy)

☐ Legal guardianship (certified copy)

☐ Executor status of an estate (certified copy)

☐ Court order (certified copy)

Signature of Requestor: Date:

PATIENT INFORMATION

Last name:	First name:	Middle name:
SSN:	Date of Birth:	Date of Death:

NCCR ONLY

Date Received:	Date Mailed: