State of Nevada
Victims of Crime Program

Patient Authorization to Release Medical Information

Submit with Request for Lost Wage or Income Reimbursement Due to Crime Related Disability

Victim/Applicant Name:	VOCP Claim #

Physician Information:

Name of doctor who certified victim unable to work:	Phone#	Fax #

Doctors Mailing Address:	City, State, Zip:

Patient Disability Statement:

How long were you unable to work due to your crime injuries?

From: MM/DD/YY: To: MM/DD/YY:

If you are still disabled when do you expect to return to work:

I have applied for lost wage or income assistance from the Nevada Victim of Crime Compensation Program (VOCP). In order to assist the VOCP to determine my eligibility for assistance *I hereby consent to and authorize the release* of any and all information including medical reports, histories, prognosis; treatment plans, billing information and any other information relating to my medical treatment, condition or disability to the VOCP.
This Authorization shall automatically expire without express revocation one year from the date below. This release is in compliance with all HIPAA regulations.

The information provided herein is true and accurate to the best of my information and belief

Applicants Signature:	Date:

Telephone #	Email address:

Mail to: VOCP P O Box 94525 Las Vegas, NV 89193-1525	*Fax to:* (702) 458-5586	*Scan and email to:* *applications@voc-net.com*