# A picture containing icon  Description automatically generated

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_ MR#\_\_\_\_\_\_\_\_\_\_FIN#\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(Internal use only)*  (*Internal use only)*

I authorize:

**Northern Nevada Medical Center** (circle one) **Northern Nevada Sierra Medical Center**

to disclose medical information or copies of my medical records to (physician, agency, individual):

Name

Address

City, State, Zip

Phone Fax

Reason for release: Continuity of care Legal Other (specify)

## Date(s) of service

Date medical records needed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email completed requests to: nnhsroirequest@uhsinc.com / Fax request to 775-799-5370

### Record transport via \_ \_\_ mail \_ \_\_ pick-up \_\_ \_\_\_ fax \_ email

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request to review my medical record in person\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Description of Information to be Released: (***(Check ALL that apply)*

 Industry Standard (Discharge Summary, History & Physical, Consult Reports, Operative Reports, Test Results)

 Discharge Summary History and Physical Operative Reports Physician Orders

 ED Record Only Progress Notes Radiology Reports EKG/EEG

 Consultation Reports Radiology Images (CD) Lab Reports Pathology Reports

 Billing Record Other (specify)

List a date or event at which point this Authorization will expire. This date or event is not to exceed one year from the date of the request. (Fill in the Date or the Event but not both.)

**Date:**        **Event:**

|  |
| --- |
| I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Initial)** |
| I understand that:1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise in the addendum to this release form.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
 |

## Signature of patient/parent/guardian/legal representative Date

If not patient, indicate relationship (Proof may be required) Witness



Patient label