NORTHERN NEVADA HOPES *your partner in health.*

# Adult Authorization: Release of Information

This form authorizes the release of Protected Health Information (PHI) pursuant to CFR Parts 160 and 164.

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PATIENT NAME PATIENT ID DATE OF BIRTH

*I authorize Northern Nevada HOPES to exchange information with the following agencies and/or individuals:*

☐ Renown Health ☐ St. Mary's Health ☐ Northern Nevada Medical Center

☐ Carson Tahoe Hospital ☐ Banner Churchill Hospital ☐ Northern Nevada Adult Mental Health

☐ West Hills Other: _____

**Information to be released (please initial all that apply):**

_____ Clinic progress notes
_____ Medication lists
_____ Substance use notes
_____ HIV/AIDS or other
_____ Diagnostic test results
_____ Other (be specific)
_____ Hospital records
_____ Psychiatry notes
_____ Lab results
_____ Psychotherapy notes
_____ D/C summary

**Purpose for Release:** _____

**Dates to include: all dates of service or from** _____ to _____

**Authorization expiration date:** _____

**Notice to the Recipient of the Information**

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2 and CFR part 164). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2 or 45 CFR part 164. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Notice to Patient**

I understand that I must voluntarily and knowingly sign this authorization before any information can be released, and that I may refuse to sign, but in that event information cannot and will not be released. I also understand that treatment by this provider is not conditioned on my signing this authorization, although exceptions will be made for a) research related treatment and b) except for psychotherapy notes, for health plans were payment is conditioned on an authorization to use Protected Health Information to determine payment. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I acknowledge that I have the right to revoke this authorization at any time, and I understand that once the information is disclosed, it may no longer be protected by federal privacy law. (You may revoke this authorization in writing, in person, or by certified mail to the provider at the address above. The revocation will be affected only upon receipt, except to the extent that the Provider has acted in reliance on the authorization. Further information on the right to revoke may be provided from time to time in the Provider's Notice of Privacy Practices).

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PATIENT/LEGAL GUARDIAN SIGNATURE DATE

# REVOKE AUTHORIZATION TO RELEASE INFORMATION

I hereby revoke this authorization to release information.

_____

PATIENT/LEGAL GUARDIAN SIGNATURE DATE