



FOR OFFICE USE ONLY: PLEASE CHECK ONE

PEDIATRIC PRIMARY CARE	
PEDIATRIC BEHAVIORAL HEALTH	

Pediatric Authorization: Release of Information

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

PATIENT NAME	PATIENT ID	DATE OF BIRTH
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I authorize Northern Nevada HOPES to exchange information with the following agencies and/or individuals:

- | | | |
|--|--|--|
| <input type="checkbox"/> Renown Health | <input type="checkbox"/> St. Mary's Health | <input type="checkbox"/> Northern Nevada Medical Center |
| <input type="checkbox"/> Carson Tahoe Hospital | <input type="checkbox"/> Banner Churchill Hospital | <input type="checkbox"/> Northern Nevada Adult Mental Health |
| <input type="checkbox"/> West Hills | | |

Type	Family Member
Name	
Address	
Address Line 2	
Phone/Fax	

Type	Family Member
Name	
Address	
Address Line 2	
Phone/Fax	

Type	Foster Family
Name	
Address	
Address Line 2	
Phone/Fax	

Type	Guardian Ad Litem
Name	
Address	
Address Line 2	
Phone/Fax	

Type	Therapist
Name	
Address	
Address Line 2	
Phone/Fax	

Type	Schools
Name	
Address	
Address Line 2	
Phone/Fax	

Type	Child Care Provider
Name	
Address	
Address Line 2	
Phone/Fax	

Type	Primary Care Provider
Name	
Address	
Address Line 2	
Phone/Fax	

Type	
Name	
Address	
Address Line 2	
Phone/Fax	

Type	
Name	
Address	
Address Line 2	
Phone/Fax	

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

- | | |
|--|--|
| <input type="checkbox"/> Clinic progress notes | <input type="checkbox"/> Hospital records |
| <input type="checkbox"/> Medication lists | <input type="checkbox"/> Psychiatry notes |
| <input type="checkbox"/> Substance use notes | <input type="checkbox"/> Lab results |
| <input type="checkbox"/> HIV/AIDS, other communicable diseases | <input type="checkbox"/> Psychotherapy notes |
| <input type="checkbox"/> Diagnostic test results | <input type="checkbox"/> D/C summary |
| <input type="checkbox"/> Other (be specific) _____ | |

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 where 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 anytime, 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).

PATIENT/LEGAL GUARDIAN SIGNATURE

DATE

REVOKE AUTHORIZATION TO RELEASE INFORMATION

I hereby revoke this authorization to release information.

PATIENT/LEGAL GUARDIAN SIGNATURE

DATE