NORTHERN NEVADA HOPES your partner in health.

580 W. 5th Street,Reno, Nevada 89503
(775) 786-4673 | Fax: (775) 348-2889
Website: www.nnhopes.org

Patient Authorization: MEDICAL Release of Information

This form authorizes the release of Protected Health Information (PHI) pursuant to HIPAA 45 CFR Parts 160 and 164 and 42 CFR Part 2.

PATIENT NAME PATIENT SSN DATE OF BIRTH

CONTINUITY OF CARE: (AUTHORIZING NORTHERN NEVADA HOPES TO RECEIVE INFORMATION. Please initial all that apply)

I authorize the following agencies and/or individuals to release information to Northern Nevada HOPES:

___Renown (RMC/Medical group) ___St. Mary's Health (RMC/Medical Group) ___Northern Nevada Medical Center/Medical Group
___Carson Tahoe Hospital/Medical Group ___Banner Churchill Hospital/Medical Group ___Other: _____

Specific description of the information to be released: ___Hospital Info ___D/C Summary ___ Clinic progress notes ___Other _____
Dates to include: all dates of service or from _____ to _____

Authorization expiration date: _____
My consent will expire on the date noted above, or case, event or condition closure unless I withdraw my consent.
If the expiration date is blank or longer than one year, the consent will expire 1 year from the signature date.

PURPOSE FOR RELEASE: (AUTHORIZING NORTHERN NEVADA HOPES TO RELEASE INFORMATION)

_____
(Nature and amount of information to be disclosed should be as limited and specific as possible)

I authorize Northern Nevada HOPES to release information to the following agencies and/or individuals: *(Please initial all that apply)*

___Renown (RMC/Medical group) ___St. Mary's Health (RMC/Medical Group) ___Northern Nevada Medical Center/Medical Group
___Carson Tahoe Hospital/Medical Group ___Banner Churchill Hospital/Medical Group ___Other: _____

Medical information to be released: (*Please initial all that apply*)

____ Clinic progress notes
____ Medication lists
____ Diagnostic test results
____ Lab results
____ Sexual transmitted diseases
____ HIV/AIDS
____ Other (be specific)_____

List types of health information you DO NOT WANT TO SHARE:

_____

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

Authorization expiration date: _____
My consent will expire on the date noted above, or case, event or condition closure unless I withdraw my consent.
If the expiration date is blank or longer than one year, the consent will expire 1 year from the signature date.

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, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization if the Privacy Rule prohibits such conditioning. 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) psychotherapy notes. 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 may 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 the HIPAA federal Privacy Law. I may revoke this authorization in writing, in person, or by certified mail to the provider at the address above. The revocation will be effective 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.

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

SIGNATURE OF PERSON GIVING CONSENT OF LEGAL REPRESENTATIVE DATE

PRINT NAME OF PERSON GIVING CONSENT RELATIONSHIP TO INDIVIDUAL: ___Self ___Parent ___Guardian ___Authorized Representative

REVOKE AUTHORIZATION TO RELEASE INFORMATION

I hereby revoke this authorization to release information. I understand that any information already shared with or in reliance upon my consent cannot be retrieved.

SIGNATURE OF PERSON GIVING CONSENT OF LEGAL REPRESENTATIVE DATE

PRINT NAME OF PERSON GIVING CONSENT RELATIONSHIP TO INDIVIDUAL: ___Self ___Parent ___Guardian ___Authorized Representative