

## **Authorization to Release Protected Health Information**

Patient Information			D : N /	\	
Name (First, MI, Last):					
Birthdate:	Mailing Addres	SS:			
City:	State:	Zip:	Phone	:	
I authorize Northern Nevada H Name of Agency or Individual:	<del></del>	_	<del></del>	<del></del>	
Mailing Address:		City:		State:	Zip:
Phone Number:	Fax Number:				
Purpose of Release         ☐ Treatment/Continued Care       ☐ Transfer of Care (Provider Change)       ☐ Personal       ☐ Legal Purposes         ☐ Disability Determination       ☐ Insurance       ☐ Other:					
Information to Be Released Release Via: All Written Verbal  All Past Records Date range of records: Date information needed by: Medical Notes/Procedures History & Physical Hospital Notes Hospital Discharge Summary  Laboratory/Pathology Reports Imaging Operative Reports  Cardiovascular Studies (ECHO, EKG) Any and All Records  Other:					
Preventive Care:       Immunization Records       Colonoscopy/Fit Test       Breast Imaging       Pap Smear Reports         Psychiatry*       Chemical Dependency*       Behavioral Health (Specify)*         *State and federal law protects the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):         Alcohol, Drug, or Substance Abuse Records       Yes       No Dates:       No Dates:         Mental Health Records       Yes       No Dates:       Psychotherapy Records       Yes       No Dates:					
<ul> <li>This authorization is valid for three years after the signed date unless another date is specified here:</li> <li>I may terminate this authorization in writing at any time by signing below. A termination will not change releases that happened before notice of termination. Written termination of the authorization must be turned into the Medical Records Department, along with any questions regarding the authorization.</li> <li>I understand that signing this authorization is voluntary. I can refuse to sign the authorization. I need not sign this authorization in order to assume treatment.</li> <li>Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.</li> <li>A photocopy of this authorization may be treated in the same manner as the original.</li> <li>My signature indicates that I have read and understand this form, and that I authorize the release of information as described above.</li> </ul>					
Patient (18 or older)  *If the patient is 17 years of age or young *If a Behavioral Health patient is 16 year		nt or legal guardian mu		orm, unless the patie	
Patient Name			atient Signature		Date
Parent/Legal Guardian Signature		R	elationship to Patient		
Authorization Termination Signature: _			Date:	:	