Authorization to Release Protected Health Information

NORTHERN NEVADA HOPES
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Patient Information

Name (First, M, Last): _____ Previous Name(s): _____

Birthdate: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

I authorize Northern Nevada HOPES to: ☐ **Release to** ☐ **Obtain from**

Name of agency or individual: _____ Relationship: _____

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 **(No external drives/CDs accepted)**

☐ 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)

☐ Immunization Records ☐ Colonoscopy/FIT Test ☐ Breast Imaging ☐ Pap Smear Reports

☐ Psychiatry* ☐ Chemical Dependency* ☐ Behavioral Health (Specify)*: _____

☐ Other: _____

*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: _____ HIV Testing/Results ☐ Yes ☐ No Dates: _____

Mental Health Records ☐ Yes ☐ No Dates: _____ Psychotherapy Records ☐ Yes ☐ No Dates: _____

- This authorization is valid for **3 years** after the signed date unless another date is specified here: _____
- I may terminate this authorization verbally or 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.
- I understand that signing this authorization is voluntary and I can refuse to sign. I need not sign this authorization to assume treatment.
- My substance use disorder records are protected under federal law, including 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
- Information used or disclosed pursuant to this authorization may be subject tot re-disclosure by the recipient and may no longer be protected by federal law.
- A photocopy of this authorization may be treated in the same manner as the original.
- My signature indicates that I have read and understand this form, and that I authorize the release of information as described above.

☐ Patient (18 or older) ☐ Parent of Minor ☐ Legal Guardian ☐ Title X Minor

- If the patient is 17 years of age or younger, patient's parent or legal guardian must sign and date this form, unless patient is a Title X minor.
- If a behavioral health patient is 16 or 17 years of age, both the patient and parent/legal guardian must sign and date this form.

_____ _____ _____

Patient Name Patient Signature Date

_____ _____

Parent/Legal Guardian Name Parent/Legal Guardian Signature

Authorization Termination Signature: _____ Date: _____

Verbal Termination: _____ _____ For office use only: Sign when taken: _____ BH _____ Med

Staff Name Date For office use only: Sign when scanned: _____ BH _____ Med