Northern Nevada
MEDICAL CENTER

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient____ DOB______________MR#______________

I authorize Northern Nevada Medical Center to disclose medical information or copies of my medical records to (physician, agency, individual):

Name____
Address____
City, State, Zip____
Phone______________________________________ Fax__________________________________

Reason for release: ______Continuity of care ______Legal _____Other (specify)_______________

Date(s) of service ____

The documents are being ____mailed ____picked-up ____faxed _____ other (specify)___________

Description of Information to be Released: (*(Check ALL that apply)*

☐ Industry Standard (Discharge Summary, History & Physical, Consult Reports, Operative Reports, Test Results)

☐ Discharge Summary	☐ History and Physical	☐ Operative Reports	☐ Physician Orders
☐ ED Record Only	☐ Progress Notes	☐ X-rays	☐ EKG/EEG
☐ Outpatient Record Only	☐ Consultation Reports	☐ Pathology Reports	☐ Labs

☐ Other (specify) ____

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

I request to review my medical record ______ Date_________________

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _______________ **(Initial)**

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise in the addendum to this release form.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

____ _____________________________
Signature of patient/parent/guardian/legal representative Date

____ _____________________________
If not patient, indicate relationship (Proof may be required) Witness