Authorization for Use and Disclosure of Health Information

Renown Health 1155 Mill Street, Mailbox O12 Reno, NV 89502 Fax 855-887-2777

Patient's Name: _____ _____

Date of birth: _____ Phone number: _____

Health information to be disclosed by Renown Health to:

Recipient's Name: _____ Phone #: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Fax: _____

Health information to be received by Renown Health from:

Name: _____

This Authorization is for the purpose of: ☐ Treatment ☐ Legal ☐ Patient request

☐ Other (describe): _____

Your health information will be used and disclosed as indicated below **EXCEPT** information related to treatment for drug or alcohol abuse; HIV testing, infection status, AIDS; and genetic testing. Initial next to each item to be disclosed.

____ Discharge Summary ____ ER Record ____History and Physical ____ Consultations

____ Operative Report ____ Radiology Reports ____ Lab Reports ____ Billing Records

____ Complete Record ____ Radiology Film or Radiology Compact Disk (CD)

☐ Check here **and initial** the line next to each item to release **ALL** health information **INCLUDING**:

_____Care and treatment for drug and/or alcohol abuse

_____ HIV testing, infection status, or AIDS

_____ Genetic testing

DATES OF SERVICE OR TIME PERIOD TO BE DISCLOSED: _____

I understand and acknowledge that:

- This Authorization may be revoked at any time by you in writing, except if your health information has already been used or disclosed.
- Your health information that will be used or disclosed as a result of you signing this Authorization could be re-disclosed by the recipient. If this occurs, your re-disclosed health information may no longer be protected by State or Federal laws.
- You may refuse to sign this Authorization. Your refusal will not affect your ability to obtain treatment.
- This Authorization becomes effective upon signing and will expire on (date) _____. If no date is indicated, this Authorization will expire one (1) year from the signature date.

_____

Signature of Patient Date

_____

Signature of Legal Representative Relationship Date

**** Completed by Staff Member Fulfilling Authorization ****

Date: _____ Fulfilled by: _____

MR #: _____ Account #: _____

PHYSICIAN APPROVAL FOR RELEASE OF MENTAL HEALTH NOTES TO PATIENT

_____ _____

Signature Date

List Documentation Used for Verification include copy with authorization.

_____

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