RENO BEHAVIORAL Healthcare Hospital

Address: 6940 Sierra Center Parkway Reno, Nevada 89511 | Phone: (775) 393-2200 | Fax: (775) 852-1473

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:**_____ **Last 4 digits of SSN:**_____
Current Address: _____ **Current Phone#:** _____
I hereby authorize Reno Behavioral Healthcare Hospital to release/obtain protected health information with:

Facility, Organization, Person/Self:	
Address:	
Phone:	Fax/Email:
☐Exchange verbal information ONLY	

Dates of Hospitalization: _____

Purpose for which the information will be disclosed:
☐Continuing Care ☐Legal Purposes ☐Personal Use ☐Other reasons, please specify_____

☐ I authorize the release of the following information including all records that include any substance use disorder and /or substance use disorder treatment records, or

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_____ _____
Patient's Signature (required for age 12 and older) **Date Signed**
**Patients age 11 and younger require parent/guarding signature only; based on services provided, signature of both patient and parent/guarding may be required for patients age 12-17; patients age 18 and older only sign unless there is a legal guardian. (NRS 129.050) **

Information that may be released: *(May be subject to a copying fee of 0.60¢ per page NRS 629.061)*
☐Industry Standard (Discharge summary, Discharge Medication, H&P, Psychiatric Evaluation, Labs)
☐Discharge Summary/Aftercare plan ☐Laboratory Reports ☐Medication Reconciliation
☐Physician Progress Notes ☐History & Physical ☐Psychiatric Evaluation
☐Nursing/Therapy Notes ☐Other: _____
☐ Please copy all records, I understand I will be subjected to a 0.60¢ per page fee.

_____ _____
Patient Signature Date Parent/Legal Guardian Signature Date

_____
Witness Signature Date

**Form must be completed in full in order to release medical records.

Authorization Disclosure:
I understand this authorization covers treatment related to inpatient, residential, rehabilitation, outpatient, and/or partial hospitalization services. I understand my health record may contain information relating to **drug/alcohol abuse, psychiatric conditions, or AIDS/HIV**, and further consent to the release of this information
I understand, unless otherwise marked above, my records may be disclosed **in writing, verbally, or electronically (fax/email).**
I understand that I have the right to refuse to sign this authorization to release protected health information and authorizing this disclosure is voluntary. I understand I may inspect the information to be used or disclosed. Refer to the Notice of Privacy Practices regarding authorization disclosures.
This information has been disclosed to you from records whose confidentiality may be protected by Federal Law: "Federal regulation (42 CFR, Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient." [RM 203, 7.2]

Revocation: Patient/Guardian Signature: _____ Date: _____
This consent will expire 1 year from the date above unless otherwise specified here (may not exceed 1 year).