RENO BEHAVIORAL Healthcare Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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

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

Dates of service to be released: _____

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.

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

Authorization Disclosure:
I understand this authorization covers treatment related to inpatient, residential, rehabilitation, outpatient, and 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]

This consent will expire 1 year from the date below unless otherwise specified here (may not exceed 1 year)

Patients under the age of 18 are required to have a parent or legal guardian signature.

_____ _____
Patient Signature Date Parent/Legal Guardian Signature Date

_____
Witness Signature Date

Revocation: I hereby revoke this authorization _____
Patient/Guardian Signature Date

REV: 09/19, 05/21