



Address: 6940 Sierra Center Parkway Reno, Nevada 89511 | Phone: (775) 393-2231 | Fax: (775) 852-1473

AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

Date of Birth: _____ Last 4 Social Security numbers: _____

Current Address: _____ Current Phone#: _____

I hereby authorize Reno Behavioral Healthcare Hospital to disclose/obtain protected health information to/from:

Hospital, organization, person/me:	
Address:	
Phone:	Fax/Email:

****This section MUST be completed in its entirety to be able to process the records request****

Dates of Hospitalization/Treatment: _____

Purpose for which the information will be disclosed:

☐ Legal ☐ Continued Care ☐ 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.

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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 ☐ EKG

☐ Nursing/Therapy Notes ☐ Other: _____

☐ Please copy all records, I understand I will be subjected to a 0.60¢ per page fee.

Patient's signature (required for ALL patients ages 12 and older) Date**

**Patients from 12 to 17 years of age must sign according to Nevada law as found at NRS 129.050.

Parents/Legal Guardian**Date**

Signature of the witness**Date****Release of Authorization:**

I understand that this authorization covers treatments related to hospitalization, residential, rehabilitation, outpatient, and/or partial hospitalization. I understand that my medical records may contain information related **to drug/alcohol abuse, psychiatric conditions, or AIDS/HIV**, and I give further consent to the release of this information.

I understand that, unless otherwise stated above, my records may be released **in writing, orally, 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 that I may inspect the information that is to be used or disclosed. Please see 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 expressly permitted with the written consent of the person to whom it relates, or as permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal Regulations restrict any use of the information to investigate or criminally prosecute any alcoholic or drug patient." [RM 203, 7.2]

The requested information above must be completed in its entirety to facilitate the processing of medical records.

This consent will expire 1 year from the date signed unless the revocation section is completed.

REVOCATION:

I hereby revoke the authorization given above this page.

Patient's signature**Date/Time**

Parents/Legal Guardian**Date/Time**

Witness signature**Date/Time**