CARSON TAHOE HEALTH

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**I,** _____ **Date of Birth:** _____

**Authorize:** ☐ Carson Tahoe Health **or** ☐ Other _____

**To disclose to:** _____

**For the purpose of:** ☐ Physician/Hospital ☐ Personal Use ☐ Insurance ☐ Attorney

Other_____

**For care provided on:** (date)_____ to (date)_____

I would like the following information released **(only the items marked will be released)**

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation(s)
- ☐ Operative Report(s)
- ☐ Emergency Report(s)
- ☐ Imaging Report(s)
- ☐ Imaging Films (Only available from Imaging Dept.)
- ☐ EKG/ECG Report(s)
- ☐ Lab Reports
- ☐ Other _____

I specifically authorize the release of information for the following treatments or procedures that are included in these records. **(You must initial the items requested, or they will not be released with the above record.)**

- ☐ Drug/Alcohol Abuse Treatment
- ☐ Psychiatric and/or Mental Illness Treatment
- ☐ Human Immunodeficiency
- ☐ Other – Specifically _____

I understand this consent will expire in 90 days from the date signed, unless specified in writing that I would like it extended. I understand this authorization may be revoked at any time, except to the extent that action has been taken in reliance upon it. I understand that the revocation must be made in writing and addressed to the Medical Records Custodian and delivered or mailed to 'Medical Records Dept., P.O. Box 2168, Carson City NV, 89702-2168'. I understand that the parties in receipt of these records may re-disclose my PHI (Protected Health Information) to persons or entities that are not subject to the HIPAA Privacy Regulations, resulting in my PHI no longer being protected by HIPAA Privacy Regulations.

**Date to Expire: (if this is to remain in effect longer than 90 days)** _____

**Date** _____ **Signature of Patient** _____

**Witness** _____ **Signature of Legal Representative** _____

**Reason Patient Unable to Sign** _____ **Relationship of Legal Representative** _____

45 CFR 164.508 (c)(2)(ii) The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization.

**DUE TO CONFIDENTIALITY, WE ONLY FAX UNDER HIPAA GUIDELINES**

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I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because of one of the following **(check one box)**:

☐ The purpose of the use or disclosure of protected health information is **NOT** to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.

☐ The purpose of the use or disclosure of protected health information **IS** to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was **NOT LAWFUL** under the circumstances in which it was provided.

I understand that I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person. **Signature of Requestor:** _____

Phone # 775-445-8585
Fax # 775-888-3206 or 775-884-5460
P.O Box 2168 Carson City, NV 89702