Authorization for Release of Medical Records

I, _____

Patient Name ***Date of Birth***

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

To disclose to:

Name *Address/Fax Number/Email Address where/how you would like the records sent.*

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

For care provided on: _____ **to** _____

Date *Date*

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

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation(s)
- ☐ Operative Report(s)
- ☐ Emergency Report(s)
- ☐ Imaging Report(s)
- ☐ Imaging Films (Only available from Imaging Department)
- ☐ EKG/ECG Reports
- ☐ Laboratory Reports
- ☐ Other - Specifically

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

Drug/Alcohol Abuse Treatment
Psychiatric and Mental Illness Treatment
Human Immunodeficiency Virus (HIV) Antibody Test Results

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 Record Department, 1600 Medical Parkway, Carson City, NV 89703. I understand 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 regulations.

Date to expire: (if this authorization is to remain in effect longer than 90 days)

Signature of Patient or Legal Representative

Relationship of Legal Representative **Date**

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"

Phone # 775-445-8585 Fax # 775-888-3206 or 775-884-5460 1600 Medical Parkway, Carson City NV 89703

To be completed by CTH Staff

ID Checked (initial) _____ Print Name _____

Emp. Department _____ Date Processed _____

How were the records delivered? ☐ Hand Carry Paper ☐ Hand Carry Disk/Flash Drive ☐ Mail ☐ Fax ☐ [SECURE] E-mail