CARSON TAHOE
HEALTH

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Carson Tahoe Health PO BOX 2168 Carson City NV 89702 775-445-8000

I, _____. _____.
Patient name at Time of service Date of Birth

Authorize Carson Tahoe Health to disclose COVID-19 Lab test results via methods checked below

Please release protected health information via the following methods below:

_____Telephone (results and status): _____ .
(Phone number required above)

☐ OK to leave voice mail with status or test results
☐ DO NOT leave message with status or test results

*Email and Mail may take 7-10 business days past date of result

_____Mail (results only): _____ .
(Address required above)

_____E- Mail (results only):_____ .
(email address required above)

The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message. I may review and copy the information disclosed

1. I may revoke this authorization at any time. The revocation must be in writing and must be sent/given to the address listed above. The revocation will not affect action already taken before the revocation is received.
2. This authorization will expire 12 months from the date of signature below.
3. Email of protected health information is not a secure means of transmission and will no longer be protected under federal HIPAA guidelines once sent from Carson Tahoe Health

_____.
Date

_____.
Signature of Patient or Legal Representative

_____.
Witness Signature

Internal Use: