CARSON TAHOE HEALTH

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(PLEASE PRINT)

PO OFFICE BOX 2168
Carson City, Nevada
89702-2168
775-445-8000

I _____ _____
Patient Name at the Time of Treatment — Date of Birth

Authorize: □ Carson Tahoe Health or □ Other _____

To disclose the following information to:

_____
Name of Person of Organization / Address / Fax and Phone Numbers

_____

For the purpose of: □ Physician/Hospital □ Personal Use ($0.60 per page) □ Insurance
□ Attorney ($0.60 per page) □ Other _____
If copies will be picked up at hospital, please check here □ Department is open Monday – Friday, 7:00 am – 4:00 pm
For care provided on: _____ to _____
Date — Date

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

_____ Discharge Summary
_____ History & Physical
_____ Consultation(s)
_____ Operative Reports
_____ Pathology Reports
_____ Other – Specifically Stix Reports / Records

_____ X-Ray Reports
_____ X-Ray Films (Only available in Imaging Department)
_____ EKG /ECG Reports
_____ Lab
_____ Emergency Reports

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

Employee Health ***Sign & Fax Back***
FAX# (775) 888-3226
Phone # (775) 445-8177

____ Drug/Alcohol Abuse Treatment
____ Psychiatric and Mental Illness Treatment
____ Human Immunodeficiency Virus (HIV) Antibody Test Results
____ 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 Record Custodian and delivered or mailed to: Medical Record Department, 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 HIPPA Privacy Regulations, resulting in my PHI no longer being protected by HIPPA regulations.

Date to expire (if this authorization is to regain in effect longer the 90 days): _____

_____ _____
Date — Signature of Patient

_____ _____
Witness — Signature of Legal Representative

_____ _____
Reason Patient Unable to Sign — Relationship

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

HEALTH INFORMATION

PO BOX 2168
CARSON CITY, NV 89702

Medical Records Use Only: Complete Date _____ Initials _____ Charge _____

Records were: Mailed _____ Faxed: _____ Electronically Sent _____ Hand Carried By Patient _____