Carson Tahoe Regional Health
Carson Tahoe Continuing Care Hospital
Post Office Box 2168
Carson City, Nevada
89702-2168
775/445-8000

CARSON TAHOE HEALTH

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(Please Print)

I, ______________________________ , ______________________________
Patient Name at Time of Treatment — Date of Birth

Authorize: ☐ Carson Tahoe Health or ☐ Other ______________________________

To disclose the following information to:

____
Name of Person or Organization / Address / Fax and Phone Numbers

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

☐ Other ______________________________

If copies will be picked up at hospital, please check here ☐ Department is open Monday – Friday, 8:00 am – 4:30 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 ______________________________
- ☐ X-Ray Reports
- ☐ X-Ray Films (Only available in Imaging Department)
- ☐ EKG/ECG Reports
- ☐ Lab Reports
- ☐ Emergency Reports

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
_____ Psychotherapy Notes
_____ 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, PO 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 regulations.

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

Date ____________________ Signature of Patient ____________________

Witness ____________________ Signature of Legal Representative ____________________

Reason Patient Unable to Sign ____________________ Relationship ____________________

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"

HEALTH INFORMATION MANAGEMENT

PHONE # 775-445-8585
FAX # 775-888-3206

P.O. BOX 2168
CARSON CITY, NV 89702

Medical Records Use Only: Completed Date ________ Initials ________ Charge ________ Check ID ________

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

Form DTROI Rev. (01/8/18)

Release of Information Office
Fax # 775-884-5460
Phone # 775-445-8585