Renown
REGIONAL
MEDICAL CENTER

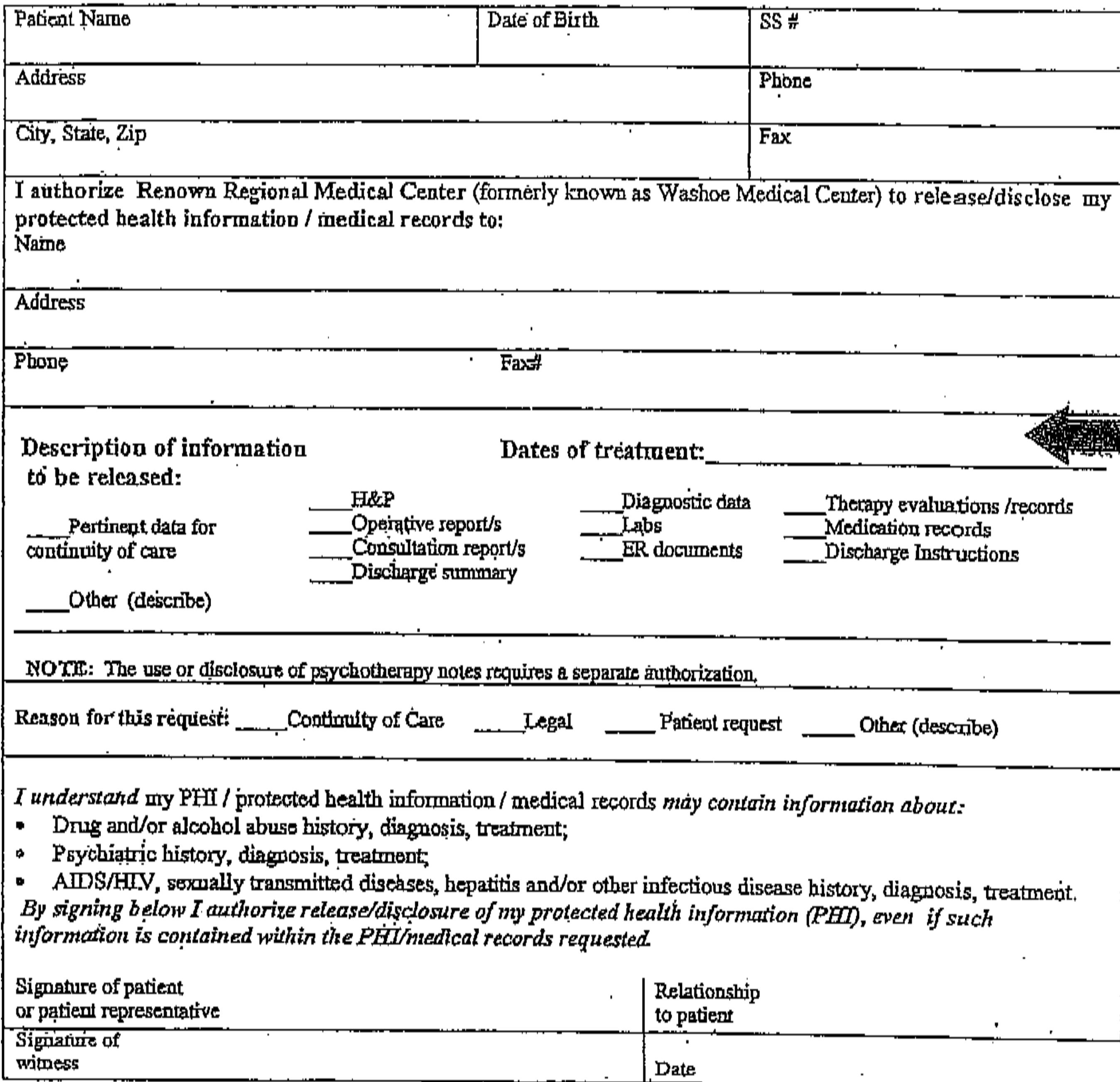
Authorization for Release / Disclosure of Protected Health Information:
May be used for continuity of care, TPO and release of PHI which is not required by law.
Copy to the individual when covered entity initiates the authorization for non-TPO reasons.

1155 Mill Street, Reno, NV 89502

Health Information Management Dept.

PHONE: (775) 982-5661
FAX: (775) 982-5372

Notice to the individual making this authorization:
1. After your medical records (PHI), are released by your authorization, the possibility exists that the recipient of your information may not be subject to federal privacy regulations and your PHI may be re-released, without your knowledge.
2. You make revoke this authorization, in writing. Your written revocation will become effective on receipt, but will not apply to any information released prior to that date.
3. This facility will not condition treatment on whether or not you sign this form.



Patient Name	Date of Birth	SS #
Address		Phone
City, State, Zip		Fax

I authorize Renown Regional Medical Center (formerly known as Washoe Medical Center) to release/disclose my protected health information / medical records to:
Name

Address

Phone Fax#

Description of information to be released: **Dates of treatment:**____________________

____Pertinent data for continuity of care
____H&P
____Operative report/s
____Consultation report/s
____Discharge summary
____Diagnostic data
____Labs
____ER documents
____Therapy evaluations /records
____Medication records
____Discharge Instructions

____Other (describe)

NOTE: The use or disclosure of psychotherapy notes requires a separate authorization.

Reason for this request: ____Continuity of Care ____Legal ____Patient request ____Other (describe)

I understand my PHI / protected health information / medical records *may contain information about:*

- Drug and/or alcohol abuse history, diagnosis, treatment;
- Psychiatric history, diagnosis, treatment;
- AIDS/HIV, sexually transmitted diseases, hepatitis and/or other infectious disease history, diagnosis, treatment.

By signing below I authorize release/disclosure of my protected health information (PHI), even if such information is contained within the PHI/medical records requested.

Signature of patient or patient representative	Relationship to patient
Signature of witness	Date

9/22/2006 rvb Renown Auth

This authorization will expire 90 days from date of signature.