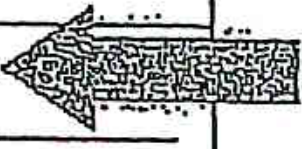


1155 Mill Street, Reno, NV 89502
Health Information Management Dept.
PHONE: (775) 982-5661
FAX: (775) 982-5372

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 may 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:  |
| <input type="checkbox"/> Pertinent data for continuity of care | <input type="checkbox"/> H&P <input type="checkbox"/> Operative report/s <input type="checkbox"/> Consultation report/s <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Diagnostic data <input type="checkbox"/> Labs <input type="checkbox"/> ER documents <input type="checkbox"/> Therapy evaluations /records <input type="checkbox"/> Medication records <input type="checkbox"/> Discharge Instructions |
| <input type="checkbox"/> Other (describe) | | |
| NOTE: The use or disclosure of psychotherapy notes requires a separate authorization. | | |
| Reason for this request: <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Legal <input type="checkbox"/> Patient request <input type="checkbox"/> 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 X | | Relationship to patient |
| Signature of witness | | Date |