AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please print clearly.

Patient Name: _____ Phone #: (_____) _____

Other Names Used: _____

Patient Address: _____ Date of Birth: _____

_____ Social Security #: _____

_____ Medical Record #: _____

Saint Mary's Facility: _____

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

I AUTHORIZE: _____
(Facility or other provider)

TO DISCLOSE TO: _____
(Persons / organizations authorized to ***receive*** the information)

at the following address: _____
(Street address)

_____
(City, state and zip code)

the following information (check box and initial applicable lines below):

- ☐ _____ Mental health (excludes "psychotherapy notes")
- ☐ _____ Substance abuse treatment records
- ☐ _____ Genetic testing information

☐ **THE FOLLOWING RECORDS,** specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

- ☐ Billing Records
- ☐ Consultation Reports
- ☐ Discharge Summary
- ☐ Emergency Room
- ☐ History and Physical
- ☐ Laboratory Tests
- ☐ Procedure Reports
- ☐ Progress Notes
- ☐ X-ray Reports
- ☐ Imaging

☐ Date(s): _____

☐ Other(s): _____

☐ **ALL RECORDS** regarding my treatment, hospitalization, and outpatient care.
A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.

PLEASE CONTINUE ON NEXT PAGE →

PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:

☐ At the request of the patient or personal representative; ***OR***

☐ Other: _____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different event or end date is specified: _____
(Insert date or event)

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: **Saint Mary's, 235 West Sixth Street, Reno, Nevada 89503, Department: Health Information Dept., Release of Information.** My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

SIGNATURE: _____ Date: _____
(Patient or personal representative)

_____ _____
Print name of personal representative Relationship to patient

Patient / Representative Identification Verified. *Initials:* _____ *Dept:* _____

Note: If the **substance abuse treatment** information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.