Authorization for Disclosure of Protected Health Information (PHI)

Please print clearly.

Patient Name: _____ Phone #: (_____) _____

Other Names Used: _____ Date of Birth: _____

Patient Address: _____ Last Four Digits of Social Security #: _____

_____

_____

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.

***SMMG charges for copies of medical records as applicable per NRS 629.061.**

I AUTHORIZE: Saint Mary's Women's Health Center

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

_____
(Street address)

_____
(City, state and zip code

_____
(Phone) (Fax)

PURPOSE: The purpose of the requested use or disclosure is:

- ☐ Provider/Continuation of care
- ☐ Personal

THE FOLLOWING RECORDS:

- A record abstract of the two (2) most recent years from the last date of service will be provided. This will include: Office Notes, Lab, Imaging results and diagnostic test results as applicable.

I specifically authorize release of the following information **(check box and initial applicable lines below)**:

☐_____ Mental health (excludes "psychotherapy notes")
☐_____ STD, AIDS and HIV
☐_____ Alcohol/drug treatment
☐_____ Genetic testing information

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

_____
(specify 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 Medical Group, 411 West Sixth Street, Reno, Nevada 89503, Attn: 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)

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.

Saint Mary's Medical Group

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