AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION ("Authorization")

NOTE: ALL sections must be completed

Patient Name: _____ Birth Date: _____
Printed (First) (MI) (Last Name)

Address: _____ Telephone #: _____
Street Address City State Zip Code

I authorize: Renown Health to *(circle one)* SEND TO *-or-* RECEIVE FROM the below entity:

_____ Telephone #: _____ Fax: _____
Full Name/Entity

Address: _____
Street Address City State Zip Code

Purpose of Request to Release:

□ Treatment □ Personal/Patient Request □ Legal/Attorney □ Insurance

□ Other (*specify*): _____

For Date(s) of Service from: _____ **to** _____[**Dates MUST be specified**]

Information To Be Disclosed:

□ Admission History & Physical □ Emergency Room Records □ Consultations □ Operative Reports

□ Progress Notes □ Radiology & X-Ray Reports □ Radiology Films/CDs □ Laboratory Reports

□ Billing Records □ Entire Record □ Other: _____

I Specifically Authorize Release of These Records (these records will NOT be released unless you <u>initial & check the box</u> to consent to release):

Initial: _____ □ Release Drug, Alcohol & Substance Abuse Records

Initial: _____ □ Release Communicable Disease Records, including without limitation, HIV/AIDS Records

Initial: _____ □ Release Genetic Testing Records

Initial: _____ □ Release Psychiatric & Mental Health/Behavioral Health Records. **Psychotherapy Records will NOT be released. Release of Psychotherapy Records requires a separate release form**. Treating physician approval is required for release of Psychiatric & Mental Health/Behavioral Health Records.

I UNDERSTAND THAT:

- This Authorization will become effective immediately and will expire on _____ [*Date*]. If no date is specified, this authorization will expire one (1) year from the signature date.
- I may revoke this Authorization at any time, in a written revocation sent to the Custodian of Records. However, I understand that my health information might have already been released.
- Information released by this Authorization might be re-disclosed by the recipient and might not be protected by state and federal privacy laws. I agree to release Renown Health from liability for release and disclosure of the released information.
- I am not required to sign this Authorization as a condition to obtain treatment, services or for eligibility of benefits. My signature on this Authorization is voluntary.

Signature of PATIENT ONLY: _____Print Name:_____ Date: _____

Signature of Person Who Is NOT the Patient: _____ Date: _____

Print Name: _____ **Authority to Sign**: _____
Proof of Authority MUST be attached (except for parents)

Address: _____ Tel No: _____

***Completed by Staff Member Fulfilling & Verifying Authorization & Completeness ***

Date: _____ Time: _____ Verified By: _____

MR #: _____ Account #: _____

List Document Used to Verify (attach a copy): _____

Physician Signature for Release of Psychiatric/Mental Health Records: _____

Printed Physician Name: _____ Date: _____

Renown HEALTH

850 Harvard Way
Mail Code B3
Reno, NV 89502
Fax: 775-982-3759

ROI Authorization

□ Tracking only
□ Mail
□ Patient Pick-up at Harvard Way