Authorization for Release / Disclosure of Protected Health Information:

This form may be used for continuity of care; treatment, payment and health care operations (TPO), and the release of protected health information (PHI) which is not required by law. Provide a copy to the patient / patient representative when Renown Health initiates the authorization for non-TPO reasons.

Renown Regional Medical Center
1155 Mill Street.
Reno, Nevada 89502

Attn: _____

PHONE: _____

FAX: _____

Notice to the individual making this authorization:

1. After your protected health information (PHI)/medical records are released by your authorization, the possibility exists that your PHI will no longer be subject to the protection of federal privacy regulations and may be redisclosed by the recipient.
2. You may revoke this authorization at any time in writing. Your written revocation will become effective upon receipt, but will not apply to any PHI released prior to that date or to the extent that the referenced Renown Health entity has taken action in reliance upon this authorization.
3. Renown Health will not condition treatment on whether you sign this form.

THIS AUTHORIZATION WILL EXPIRE 90 DAYS AFTER THE DATE OF SIGNATURE.

Patient Name	Date of Birth	Social Security Number
Address		Phone
City, State, Zip		Fax

I authorize (you must check the blank that applies):

_____ The provider listed below to release / disclose the PHI described below to the above-referenced Renown entity

_____ The above-referenced Renown entity to release / disclose the PHI described below to:

Provider Name	
Address	Phone
City, State, Zip	Fax

Description of information to be released for the following dates of treatment / service: _____

____ Physician generated data	____ Discharge instructions	____ Diagnostic data	____ Therapy evaluation / records
____ H&P	____ ER documents	____ Labs	____ Medication records
____ Operative reports	____ Diagnostic imaging		
____ Consultation report/s	____ Other (describe): _____		
____ Discharge summary			

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 that my PHI / 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 the release / disclosure of my PHI even even it contains information regarding the above-listed types of information within the PHI / medical records requested.

Signature of patient or personal representative:	Date:
Print name of personal representative:	Representative's authority:

For Renown Health Personnel Use Only

Renown Health Patient Medical Record No.	