AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please print clearly. Email _____

Patient Name _____ Phone # (_____) _____

Other Names Used _____

Patient Address _____ Date of Birth _____

_____ 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.

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) may contain:

_____ Mental health (excludes "psychotherapy notes") _____ Substance abuse treatment records

THE FOLLOWING RECORDS, specific types of health information, or records for the date(s) of service as specified (check applicable boxes)

_____ Billing Records _____ Run Report _____ Dispatch Record $75.00 per audio

_____ Other (please specify)_____

For Date(s) of Service: _____ , _____ , _____ .

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:

REMSA (Regional Emergency Medical Services Authority) • 450 Edison Way • Reno, NV 89502 • Attn: Medical Records

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
(Continued on reverse side)

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Information disclosed pursuant to this authorization would 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: _____

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.