

Carson Valley Medical Center
 1107 Highway 395 South
 Gardnerville, Nevada 89410
 775-782-1500 Ext.1734
 Fax 775-782-1515

Authorization for Release/Disclosure of Protected Health Information
 May be used for continuity of care, TPO and release of PHI which
 is not required by law. Copy to the individual when covered entity
 initiates the authorization for non-TPO reasons.

Notice to the individual making this authorization:

1. After your medical records (PHI) are released by your authorization, the possibility exists that the recipient of your information may not be subject to federal privacy regulations & your PHI may be re-released without your knowledge.
2. You may revoke this authorization, in writing. Your written revocation will become effective on receipt, but will not apply to any information released prior to that date.
3. CVMC will not condition treatment on whether or not you sign this form.

Patient Name	Date of Birth	SS#
Address		Phone
City, State, Zip		Fax
I hereby authorize the following health care facility to release my records to Carson Valley Medical Center:		
Facility Name		
Address		
Phone	Fax #	
Description of Information To be Released:	Dates of Treatment _____	
_____ Pertinent Data for	_____ H&P	_____ Diagnostic Data
_____ Continuity of Care	_____ Op Reports	_____ Labs
_____ Other	_____ Consults	_____ ER Documents
		_____ Therapy evaluations/records
		_____ Medication Records
		_____ Discharge Instructions
		_____ Discharge Summary
NOTE: I may request a copy of this authorization		
Reason For This Request: _____ Continuity of Care _____ Legal _____ Patient Request _____ Other (describe)		
I understand my PHI/protected health information/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 release/disclosure of my protected health information (PHI), even if such information is contained within the PHI/medical records requested.		
Signature of Patient Or Patient Representative		Relationship to Patient
Signature Of Witness		Date

This Authorization will expire one year from date of signature