DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
RELEASE OF PROTECTED HEALTH (PHI) CONSENT FORM

Name: _____ Date of Birth: _____SS #: XXX-XX-_____
Street Address: _____City: _____State: _____ Zip: _____
Phone #:_____Alt. #: _____

I authorize the following Agency to release my Protected Health Information (PHI) for the specified dates:

- ☐ **LAKE'S CROSSING: Dates of Service: _____**
- ☐ **NNAMHS: Dates of Service: _____**
- ☐ **RURAL HEALTH CLINIC Dates of Service: _____**
- ☐ **SNAMHS: _____Rawson-Neal _____ Stein_____ Medication Clinic Dates: _____**
- ☐ **OTHER: _____ Dates: _____**

INFORMATION TO BE RELEASED: **(Individual MUST INITIAL each item of information to be released)**

_____ Psychiatric/Drug/ Alcohol Information		**_____HIV/AIDS Information**
_____Consultation Reports	_____History & Physical Exam	_____Treatment Plans
_____Diagnosis (psychiatrist)	_____Discharge Summary	_____ Outpatient Counseling
_____Psychiatric Evaluation	_____Medication Records	_____ Service Coordination
_____Psychological Assessment	_____ Progress Notes	_____ Case Management
_____General Summary Letter Only	_____ Nursing Notes	_____ Lab / EKG Results

_____Other (Specify):_____

RELEASE TO:
Name/Agency (Recipient Name): _____ Phone#: _____
Street Address: _____City: _____State: _____ Zip: _____

MUST BE INITIALED: _____Written Disclosure _____Verbal Disclosure _____Transmitted electronically_____
Electronic transfer/E-mail address: _____Fax #: (If different from above) _____

PURPOSE OF RELEASE:
_____ Continuation of Care _____ Self/Personal
_____ Insurance SpecifyPurpose: _____
_____ Legal

INFORMATION FOR INFORMED CONSENT

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including Nevada Revised Statutes and Title 42 of the Code of Federal Regulations. These Statutes, Rules and Regulations require that the individual give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations. Any violation of these regulations may be directed to the United States Attorney for the judicial district in which the violation occurs. A general authorization for the disclosure 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. Re-disclosure of information pertaining to identification of an individual as having been diagnosed, treated, or referred for treatment for a substance use disorder is prohibited.

Consent to release information will be considered valid only when it states: (1) who will release the information; (2) who will receive the information; (3) the purpose for which the information will be used; (4) what specific information will be released; and (5) when the consent will expire. The consent must contain the individual's or authorized representative's signature and the date of the signature. The authorized representative signing for the client must submit a copy of the legal document(s) granting this authority.

This authorization for the Release of Medical Information waives any and all rights that the individual now has or in the future may have to bring any legal action against the releasing person/facility for any damages caused directly or indirectly by the release of this information or other confidential information. Upon request, the individual will be given a copy of the completed "Authorization for the Release of Protected Health Information."

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. Otherwise, this authorization expires_____ days from the date of signing (but no longer than 365 days) or upon case closure, whichever occurs first.
A PHOTOCOPY, FACSIMILE OR ELECTRONIC SUBMISSION OF THIS FORM IS AS VALID AS THE ORIGINAL

Client or Legal Representative Signature: _____ Date: _____
Relationship to Client: _____ Witness Signature: _____

Guardians and Durable Power of Attorney designees should include a copy of the applicable paperwork with this request)

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REVOCATION:

I hereby revoke the authorization given on the reverse side of this page

_____Date/Time_____

Signature of Patient

_____Date/Time_____

Signature of Guardian/Representative (Legal documents required)

_____Date/Time_____

Signature of Witness