Name: _____ Social Security #:_XXX-XX-_____Birth date:_____

INFORMATION TO BE RELEASED FROM:

Name/Agency (above): _____ Phone #:_____

Address: _____ Fax #: _____

INFORMATION TO BE RELEASED TO:

Name/Agency (Recipient Name): _____ Phone: _____

Address: _____ Fax #: _____

MUST BE INITIALED: _____Written Disclosure _____Verbal Disclosure _____ Electronic transfer / FAX

E-mail address: _____ Fax #: (If different from above)_____

PURPOSE OF RELEASE: _____ Personal _____ Legal _____Other: ____CONTINUITY OF CARE_____

DATE(s) OF SERVICE: FROM _____ TO _____

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

_____ Psychiatric/Drug/ Alcohol Information **_____HIV/AIDS Information**

_____Consultation Reports
_____Diagnosis (psychiatrist)
_____Psychiatric Evaluation
_____Psychological Assessment
_____ General Summary Letter Only
_____Other (Specify):_____

_____History & Physical Exam
_____Discharge Summary
_____ Medication Records
_____ Progress Notes

_____Treatment Plans
_____ Lab / EKG Results

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

Date: _____ Date: _____

_____ _____
Signature of Parent/Guardian/Representative) Signature of Client

_____ _____
Relationship to Client Signature of Witness

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

The following information was released to: (list by MR # and date i.e., MR 103 2/14, 3/15)

____________________ ____________________ ________________ ________________
____________________ ____________________ ________________ ________________
____________________ ____________________ ________________ ________________

Was released to: ____
____

Via □ mail □ verbal □ fax □ e-mail

□ Picked up by: ______________________________ Date: ________Time____

(signature required)

Released by: ____ Date: _________Time________

The following information was released to: (list by MR # and date i.e., MR 103 2/14, 3/15)

____________________ ____________________ ________________ ________________
____________________ ____________________ ________________ ________________
____________________ ____________________ ________________ ________________

Was released to: ____
____

Via □ mail □ verbal □ fax □ e-mail

□ Picked up by: ______________________________ Date: ________Time____

(signature required)

Released by: ____ Date: _________Time________

The following information was released to: (list by MR # and date i.e., MR 103 2/14, 3/15)

____________________ ____________________ ________________ ________________
____________________ ____________________ ________________ ________________
____________________ ____________________ ________________ ________________

Was released to: ____
____

Via □ mail □ verbal □ fax □ e-mail

□ Picked up by: ______________________________ Date: ________Time____

(signature required)

Released by: ____ Date: _________Time________

NAME: ______________________________

Medical Record#: _____________________