UNIVERSITY OF NEVADA, RENO

STUDENT HEALTH CENTER

1664 N. Virginia St. MS 196 Reno, NV 89557

Phone: 775-784-6598

Fax: 775-784-1298

Authorization to Obtain or Disclose Protected Health Information

This form must be complete in order for request to be fulfilled

Patient name: _____ Date of birth: _____

Previous name (if applicable): _____ Last seen at Student Health _____

Student ID # : _____ Phone: _____

I want my medical records to be received FROM:

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____ Fax: _____

I want my medical records to be sent TO:

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____Fax: _____

Records I want to be sent are: (Please check applicable box(es) ☐ **Verbal Disclosure Only**

MEDICAL

- ☐ All my health information
- ☐ ONLY my specified info below
- ☐ Chart Notes
  - ☐ Immunizations
  - ☐ Lab/X-ray results
  - ☐ Sexual Health (STI Tests & Treatment)
  - ☐ Other: _____

COUNSELING

- ☐ Progress Notes
- ☐ Testing Summary
- ☐ Other: _____

- Release of psychotherapy notes requires a separate authorization form.

This information for which I'm authorizing disclosure will be used for the following purpose:

☐ My personal records ☐ Other health care providers ☐ Disclose to Parent ☐ Other (describe)_____

My Rights

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken. This authorization will expire 90 days from date of signature and I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. The University, Provider, and its employees, officers, and healthcare providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized. **A copy fee of $.60 per page applies to my request per NRS629.061**.

Specific Authorization: I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information. Response time for medical record requests may be 1-30 days, NRS629.061

Patient Signature_____ Date of Request_____

Office Use Only: Completed_____ By:_____ Mailed Faxed Pick-up

Recipients of Alcohol/Drug/Infectious Disease/Mental Health Records: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2) and state law. These laws prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or state law. A general authorization for the release of medical 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.