Reno Psychiatric Associates

6151 Lakeside Dr. STE 2001 Reno, NV

P: (775) 329-4284 F: (775) 329-2550

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF MEDICAL RECORDS AND INFORMATION

Information to be released **TO**: Phone Number:

Address: Fax Number:

Information to be released **FROM**: Reno Psychiatric Associates, 6151 Lakeside Dr. STE 2001 Reno, NV 89511.

Phone: (775) 329-4284. Fax: (775) 329-2550.

I hereby waive my medical privilege and my rights of privacy and privilege as to any and all of my protected Individually Identifiable Health Information as defined, set forth and promulgated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and authorize the above noted release, disclosure to include any and all:

Medical records, physical examination records, treatment records, diagnostic evaluations, prognoses, opinions and/or documents reflecting descriptions and nature of disability, diseases, conditions, hospitalization, surgical procedures reports, all other reports, office notes, nurses notes, any other handwritten notes, initial intake questionnaires and patient information sheets, medical histories, sign-in sheets, computer records, x-rays, MRI, CT Scans, laboratory and other diagnostic test results, pharmaceutical records, prescriptions, medicines and drugs furnished, referrals, missed appointments, workers' compensation claim information and documents filed or compiled in opposition to such claims, physical therapy records, invoices, statements, bills, payments and correspondence received from or rendered to other persons.

You are further authorized and directed to permit **Reno Psychiatric Associates** to make copies of all documents, materials, notes and records, including duplicate x-rays and other films, which are in your possession or in your control in accordance with the foregoing. This authorization is at the patient's request. This authorization for release and disclosure does not expire unless a request is received in writing or indicated here: _____

THE INFORMATION AUTHORIZED FOR RELEASE AND DISCLOSURE MAY INCLUDE INFORMATION RELATING TO THE FOLLOWING CONDITIONS: ▪ THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASES WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, AND GONORRHEA

▪ HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) ▪ BEHAVIORAL OR MENTAL HEALTH SERVICE / PSYCHIATRIC CARE

▪ TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE

▪ RESULTS OF BLOOD, BREATH, AND URINE TESTS

I am aware that once the information authorized for release is disclosed, the receiving party has the right to use the information and/or re-disclose the information and the information may no longer be protected by Federal privacy regulations and laws. I am aware that I may revoke this authorization at any time by notifying, in writing, **Reno Psychiatric Associates** of my desire to revoke. I am further aware that any use, action, disclosure or release made in reliance of this document prior to revocation is not included or considered as part of or subject to the revocation. I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization. I am aware that a photocopy of this authorization is to be given the same force and effect as the original.

NAME (printed): _____ DOB: _____

SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN (printed):_____DATE: _____

PARENT/GUARDIAN(signature):_____