

West Hills Hospital / Willow Springs Center

Authorization for Use or Release of Information

Page One of Two

Addressograph

FOR THE RECIPIENT OF THE INFORMATION

If any of the requested records contain information regarding alcohol or drug treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release 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.

I hereby authorize: **West Hills Hospital** **Willow Springs Center** **Other (Specify)**
(Check One) 1240 East Ninth Street 690 Edison Way Name: _____
Reno, NV 89512 Reno, NV 89502 Address: _____
(775) 323-0478 (775) 858-3303 Phone Number: _____

To use or release health information and records obtained during the course of treatment of:

Patient Name: _____ Date of Birth: _____
Address: _____ Patient's Phone: _____
Social Security No.: _____
Date of Death: _____

1. The information is to be used or disclosed to the following person or organization:

Person / Entity Name: _____
Address: _____
Phone Number(s): _____

2. Purpose: The purpose of this use or disclosure is:

At the request of the patient and / or parent / guardian
 Other: _____

3. Information to be used or disclosed

The information to be used or disclosed includes only those items checked below, with respect to services provided on or around (insert dates of service): _____. If this line is left blank, the treatment dates covered by this authorization are from preadmission to discharge and claims resolution.

I understand that this authorization extends to all or any part of the records / information designated below which may include treatment for physical and mental illness, alcohol / drug abuse, HIV / AIDS test results or diagnoses. The information to be used or disclosed includes:

- | | |
|--|---|
| <input type="checkbox"/> Demographics / Face Sheet | <input type="checkbox"/> Physician's Orders |
| <input type="checkbox"/> Discharge Planning Sheet | <input type="checkbox"/> Laboratory Data |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> EKG Data |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Psychiatric Assessment | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> Psychosocial Assessment | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Educational Assessment | <input type="checkbox"/> Verbal Communication with: |
| <input type="checkbox"/> Consultation Reports | Name: _____ |
| <input type="checkbox"/> Billing / Financial Records | Relationship: _____ |

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Patient's Name: _____

Addressograph

This authorization is limited to only the information that I have requested on page one to be used or disclosed to the persons / facilities named herein.

I hereby release: West Hills Hospital Willow Springs Center
from all legal responsibilities of liability that may arise from the use or disclosure of medical records an other health information in reliance on this authorization.

If the patient is a minor, relevant state law should be followed with respect to the required signatures. West Hills Hospital and Willow Springs Center will not condition treatment, payment, or eligibility for benefits on whether this authorization is signed.

1. **Expiration:** I understand that unless I revoke the authorization earlier, this authorization will automatically expires 180 days, or according to the relevant state law, from the date this authorization.
2. **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by Federal law, and could be used or re-disclosed by the receiving party.
3. **Refusal to Sign:** I understand that I may refuse to sign this authorization and that West Hills Hospital or Willow Springs Center will not condition treatment on whether I sign this authorization.
4. **Certification:** I certify that I am (check whichever applies) –
 The patient, and the identification that I have provided is true and correct
 The patient's authorized representative, and that the identification and proof of authority that I have provided is true and correct. My relationship to the patient is that of: _____
5. **Revocation:** I have the right to stop the use or disclosure of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.
6. **Copy:** I understand that I will receive a copy of this completed form.

(Patient's Signature – Ages 12 and older)

(Date)

(Parent / Guardian Signature)

(Date)

(Staff Member / Witness Signature)

(Date)

Internal Use Only

I have received _____ as documentation that verifies the relationship with the patient and the authority to receive health information of the patient.

(Employee Signature)

(Print Last Name)

(Date)