NORTHERN NEVADA PEDIATRICS

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date of Birth:**_____
Patient Address:_____
Home Phone:_____

INFORMATION TO BE REALEASED BY:	INFORMATION TO BE RELEASED TO:
_____ Organization/Name _____ Street Address City, State, Zip _____ Phone Fax	Northern Nevada Pediatrics 75 Pringle Way #301 Reno, NV 89502 (775)686-4300 (Phone) (775)686-4317 (Fax)

TYPE OF MEDICAL INFORMATION REQUESTED:
_____Patient's entire medical chart
_____Progress notes _____Hosp/OP report _____Radiology Reports _____Lab Reports
_____Mental Health reports _____Alcohol/Substance Dependency Reports
_____HIV (AIDS) Antibody Test Results and Diagnosis/Treatment Records
_____Other:_____

REASON FOR REQUEST: ___ Personal ___ Transfer of Care ___ Insurance ___ Legal ___ Continuing Care ___ Other

The authorization and consent will expire 90 days from the date of this authorization.

There is a fee of $0.60 per page for copy of medical records to any party excluding physicians.

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected healthcare information.

You may revoke or terminate this authorization by submitting a written revocation, sent by certified mail, to Northern Nevada Pediatrics, Attention: Medical Records, 75 Pringle #301, Reno, NV 89502. The revocation will become effective only upon receipt, except to the extent the Provider has acted on reliance of the authorization or the authorization was obtained as a condition of obtaining health insurance coverage and the insurer wishes to use the protected health information to lawfully contest a claim.

I understand that treatment by Northern Nevada Pediatrics is not conditioned on my signing this authorization, although exceptions will be made for research related treatment, for treatment the purpose of which is creating protected health care information for a third party and except for psychotherapy notes, for health plans who condition enrollment or on an authorization requested prior to enrollment, or where payment is conditioned on an authorization to use PHI to determine payment.

Patient Signature:_____ Date:_____
Or
Parent or Legal Guardian:_____Date:_____

Relationship to Patient:_____