Washoe County Health District
1001 E. 9TH St, Bldg. B, P.O. Box 11130, Reno, NV 89520-0027

AUTHORIZATION FOR RELEASE OF INFORMATION

For office use only
Record faxed to: (______)_______________
Record faxed on ______________________ (date)
By_______________________________ (clerk)

This is to certify that permission is hereby granted to release information as follows:

Information to be **released for** ____ ________________________
Name of patient (LAST NAME, FIRST NAME) Date of Birth

Information to be **released by:** ☐ Washoe County Health District ☐Other __________________________ (____) _________
Name of Physician, Clinic, Agency, Other Fax number

Information to be **released to** ____ (_______) ____________________
Name of person, physician, clinic, agency, other Fax number

Address to send record ____
Address City State Zip

This protected health information is being released for the following purpose:

☐Treatment ☐Payment ☐ At the request of the individual ☐Other___________________________________

Information to be released: Dates of service to be included: ____

Type(s) of service provided: ____

Information released: ☐ Nurses notes ☐ Doctors orders ☐ Other____________________________
☐ Lab/Diagnostic tests ☐ Entire patient record (including records from other health care providers)

INFORMED CONSENT

By signing below, I understand that:

- This Authorization form is good until ________________________ or until I ask in writing for it to end, whichever comes first. (Date – 1 year maximum)
- I have the right to stop this Authorization form by FAXing a request to the Program listed below or writing to the Washoe County Health District at P.O. Box 11130, Reno, NV 89520
- If I stop this Authorization form, it will not effect sharing of my health information that has already happened.
- Any information used or shared with my permission in this Authorization form may be shared by the person or place receiving the health information. Once the health information is shared, it may no longer be protected by federal or state law.
- I may refuse to sign this Authorization form, but my records cannot be shared without my signature.
- My signing or not signing of this Authorization form will not change the services I receive at the Washoe County Health District including my treatment, payment, enrollment or eligibility.
- I have a right to look at or copy the information that will be used or shared because of this Authorization form.
- If by law the Washoe County Health District cannot send the protected health information to the place listed above, please initial in the following space if you want a copy of the information sent to you directly: __________.

He leído y entendido este formulario en español. (Iniciales aquí y firma abajo por favor) _____

Date Fecha	Authorized Signature (Patient, Parent/Guardian, Other) Firma (paciente, padre de familia/tutor, Otro)	Relationship to patient Relación al paciente	Phone Number Número de teléfono

Please check the program for the records requested and FAX to that program.

☐ Tuberculosis (TB) Clinic	☐ STD, HIV or Family Planning	☐ Immunization Clinic	☐ Home Visiting
PH: 775-785-4785	PH: 775-328-2470	PH: 775-328-2441	PH: 775-328-2628
FAX: 775-785-4790	FAX: 775-325-8029	FAX: 775-328-6102	FAX: 775-328-3750