



1107 HWY 395 \* Gardnerville \* NV \* 89410  
 Phone (775) 783-3086 \* FAX (775) 782-1515

**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_ Cell#: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I hereby authorize Carson Valley Medical Center (CVMC) to release the health information indicated below that is contained in my medical to the recipient named below. **I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/ drug abuse and/ or HIV/ AIDS test results or diagnoses.**

Name of Recipient: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 (Please Print)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Reason for Disclosure:  Continuity of Medical Care  Self  Legal  Other: \_\_\_\_\_

Past Dates of Treatment: \_\_\_\_\_

**Information to be released (check all that apply):**

<input type="checkbox"/>	<b>All Pertinent Data</b>	<input type="checkbox"/>	Pathology Reports
<input type="checkbox"/>	Emergency Department Reports	<input type="checkbox"/>	Laboratory Reports
<input type="checkbox"/>	Discharge Summary Reports	<input type="checkbox"/>	Radiology Reports
<input type="checkbox"/>	History and Physical	<input type="checkbox"/>	Operative Reports
<input type="checkbox"/>	EKGs	<input type="checkbox"/>	Consults
<input type="checkbox"/>	Physical/ Occupational Therapy Reports	<input type="checkbox"/>	Other: _____

This consent is subject to revocation at any time except to the extent the action has been taken thereon. **This authorization and consent expire one year from the date of authorization written below.** I understand that the recipient of my health information may be charged for the service of releasing medical information. Your health care or payment for care will not be affected by whether or not you sign this authorization. Once your health information is released, re-disclosure or your health care information by the recipient may no longer be protected by law.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Signature of Patient/ Patient's Personal Representative      Printed Name      Date

\_\_\_\_\_  
 Relationship, if not patient      Witnessed by

*If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate with an executor or administrator estate paperwork must accompany authorization. Exception: Parent signing for patient under the age of 18, if the patient is not emancipated.*

**For Healthcare Facility Use Only**

<b>Date Received:</b> _____	<b>Date Completed/Sent:</b> _____
<b>Copy of ID obtained:</b> _____	<b>Completed by:</b> _____