State of Nevada
Division of Mental Health and Developmental Services
Authorization to Release Protected Health Information

Agency (check one): ___Rural Clinics ___NNAMHS (Northern NV Adult Mental Health Services)
___Lakes Crossing ___SNAMHS (Southern NV Adult Mental Health Services)

Name: _____ **Social Security #:**_____**Birth date:**_____
INFORMATION TO BE RELEASED FROM:

Name/Agency (above):_____

Address: _____
INFORMATION TO BE RELEASED TO:

Name/Agency: _____

Address: __ _____

PURPOSE OF RELEASE:_____

_____**Written Disclosure** _____**Verbal Disclosure (Initial one or both disclosure types)**

INFORMATION TO BE RELEASED: (Individual must initial each item of information to be released)

_____Consultation Reports
_____Diagnosis (psychiatrist)
_____Discharge Summary
_____Drug and Alcohol Abuse Info.
_____ General Summary Letter Only
_____History & Physical Exam
_____HIV/AIDS Info.
_____Medication Records
_____Progress Notes
_____Treatment Plans
_____Psychiatric Evaluation
_____Psychological Assessment
_____Other (Specify):_____

INFORMATION FOR INFORMED CONSENT

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including Nevada Revised Statutes and Title 42 of the Code of Federal Regulations. These Statutes, Rules and Regulations require that the individual give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations.

Consent to release information will be considered valid only when it states: (1) who will release the information; (2) who will receive the information; (3) the purpose for which the information will be used; (4) what specific information will be released; and (5) when the consent will expire. The consent must contain the individual's or authorized representative's signature and the date of the signature. The authorized representative signing for the client must submit a copy of the legal document(s) granting this authority.

This authorization for the Release of Medical Information waives any and all rights that the individual now has or in the future may have to bring any legal action against the releasing person/facility for any damages caused directly or indirectly by the release of this information or other confidential information. Upon request, the individual will be given a copy of the completed "Authorization for the Release of Protected Health Information."

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. Otherwise, this authorization expires_____ days from the date of signing (but no longer than 365 days) or upon case closure, whichever occurs first.

Date: _____ **Date:** _____

_____
Signature of Parent/Guardian/Representative)

_____
Signature of Client

_____
Relationship to Client

_____
Signature of Witness

MHDS **Authorization for Release of Protected Health Information Form** **MHDS** **Rev. 11/2012**	NAME: _____ Medical Record#_____

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