AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date of Birth:**_____ **Phone #:**_____
(please print)

I authorize:	**To Release to:**
Willow Springs Center Name of Person or Entity	Name of Person or Entity
690 Edison Way Address	Address
Reno, Nevada 89502 City	City, State, Zip
Phone # (775) 858-4525 Fax # (775) 858-4520	Phone # Fax #

Information that may be released: (Ind. Standard will be released unless specific need for additional information)

☐ **Industry Standard (Discharge Summary/Plan, Medication Reconciliation, H&P, Psych Eval, Labs)**

☐ Medication Record ☐ Psychiatric Evaluation ☐ Consultation Reports ☐ Psychological Testing
☐ History & Physical Exam ☐ Laboratory Studies ☐ Radiology Findings ☐ Physician Progress Notes
☐ Psychotherapy Notes ☐ Aftercare Plan ☐ Discharge Summary ☐ Verbal Communication
☐ Other (specify) _____

Do **not** release the following:_____

Treatment Dates to be Released:_____

PURPOSE FOR WHICH INFORMATION IS TO BE USED: (copy fee $.60 per page)

___ Continuing Care ___ School ___ Disability benefits
___ Legal ___ Personal ___ Employment conditions

If for legal purposes, give specific reason: (must be completed)_____

AUTHORIZATION:

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Revocation must be in writing. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. Refer to the Notice for Privacy Practices regarding authorized disclosures. A legible copy of the Authorization or my signature thereon may be used with the same effectiveness as an original.

OTHER CONDITIONS:

This information has been disclosed to you from records whose confidentiality may be protected by Federal Law: "Federal regulation (42 CFR, Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the 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." [RM 203, 7.2] Rev. 4-12-04

This consent expires one year from the date below unless otherwise specified: (not to exceed one year)_____

Patients age 11 and younger require parent/guardian signature only; Based on services provided, signature of both patient and parent/guardian may be required for patients age 12-17; patients age 18 and older must sign exclusively unless there is a legal guardian.

By marking the lines below, I signify that I consent for the following type(s) of information to be released to the above individual/entity.

___ Psychiatric conditions ___Drug/Alcohol Abuse
___ Medical conditions ___HIV or AIDs related information

_____ _____ _____ _____
Signature of Patient **Date** **Signature of Parent/Guardian, if applicable** **Date**

Revocation: I hereby revoke the above authorization: Signature_____ ***Date***_____