RENO HEART INSTITUTE

HIPAA Release Form

Section I – Organization / Group

I, _____, give my permission for

- ☐ Northern Nevada Medical Center / Medical Group
- ☐ Saint Mary's Medical Center / Medical Group
- ☐ Renown Medical Center / Medical Group
- ☐ Northern Nevada Sierra Medical Center / Medical Group
- ☐ OTHER: _____

to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:

☐ Disclose my complete health record including, **but not limited to**, hospital and office notes, testing and procedure results, lab test results, treatment history, and billing records for all conditions.

Or

☐ Disclose my complete health record **EXCEPT** for the following information

- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other (Specify) _____

Form of Disclosure:

- ☐ Electronic copy or access via a web-based portal / Hard Copy
- ☐ Hard copy only

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Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information.

☐ At My Request

☐ OTHER: _____

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: Office of Dr. Devang M. Desai, MD

Organization: Reno Heart Institute

Address: 10623 Professional Circle, Suite A, Reno, NV 89521

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

Tick as appropriate

☐ All past, present, and future periods

☐ From _____ To _____

☐ The date of the signature in section VI until further notice or revoked.

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: Office of Dr. Devang M. Desai, MD

Organization: Reno Heart Institute

Address: 10623 Professional Circle, Suite A, Reno, NV 89521

I understand that:

1) If my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my healthdata.
2) I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section
3) The failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I received

Section VI – Signature

Print your name: _____

Date: _____

Patient Signature _____

If this form is being completed by a person with legal authority to act an individual's behalf,such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form:

Describe below how this person has legal authority to sign this form:

_____

_____

_____

_____