HIPAA Release Form

**Section I – Organization / Group**

I, Click or tap here to enter text., give my permission for

 [x]  Northern Nevada Medical Center / Medical Group

 [x]  Saint Mary’s Medical Center / Medical Group

 [x]  Renown Medical Center / Medical Group

 [x]  Northern Nevada Sierra Medical Center / Medical Group

 [ ]  OTHER: Click or tap here to enter text.

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:

[x]  Disclose my complete health record including, **but not limited to**, hospital and office notes, testing and procedure results, llab 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) Click or tap here to enter text.

Form of Disclosure:

[x]  Electronic copy or access via a web-based portal / Hard Copy

[ ]  Hard copy only

# Section III – Reason for Disclosure

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

[x]  At My Request

[ ]  OTHER: Click or tap here to enter text.

**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

[x]  All past, present, and future periods

[ ]  From Click or tap to enter a date. To Click or tap to enter a date.

[ ]  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 health data.
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:** Click or tap here to enter text.

 **Date:** Click or tap to enter a 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: Click or tap here to enter text.

Signature of person completing this form:

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