Carson Valley Medical Center
YOUR COMMUNITY HOSPITAL
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):**

| | | | |
|---|---|---|---|
| | **All Pertinent Data** | | Pathology Reports |
| | Emergency Department Reports | | Laboratory Reports |
| | Discharge Summary Reports | | Radiology Reports |
| | History and Physical | | Operative Reports |
| | EKGs | | Consults |
| | Physical/ Occupational Therapy Reports | | 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**

**Date Received:** _____ **Date Completed/Sent:** _____

**Copy of ID obtained:** _____ **Completed by:** _____

*Revised: 01/2011*