Sierra Nevada SPECIALTY CARE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Information (Please print clearly, complete all sections, sign. And date)	
Name:	DOB:
Address:	City/ State/Zip:
Phone:	Last 4 of SS#:

Information- RELEASE FROM:	Information: RELEASE TO:
Name of Person/ Facility/Organization:	Name of Person/ Facility/Organization: Sierra Nevada Specialty Care
Address:	Address: 670 Sierra Rose Dr.
City/State/Zip:	City/State/Zip: Reno, NV 89511
Phone: Fax:	Phone: 775-322-4550 Fax: 775-322-4776

INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORDS:	PURPOSE OF THE DISCLOSURE:
☐ Billing ☐ History and Physical ☐ Laboratory Tests/ Imaging Reports ☐ Progress Notes/Office Notes ☐ Other:_____	☐ Continuity of Care ☐ Attorney ☐ Insurance ☐ Disability ☐ Other:_____

- I understand that I may revoke this authorization in writing submitted at any time to Sierra Nevada Specialty Care. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.
- I understand that SNSC will not condition treatment or eligibility for care on my providing this authorization except if such care is (1) research related or (2) provided solely for the purpose pf creating Protected Health Information for disclosure to a third party.
- I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR part 2, may be subject to re-disclosure by the recipient any may no longer be protected by the Health Insurance Portability and Accountability Privacy Act (45 CFR Part 164) and the Privacy Act of 1974 (5 USC 552a).

Signature:_____ Date:_____

Print Name: _____ Relationship to patient:_____