WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

Public Health
Prevent. Promote. Protect.

AUTHORIZATION FOR RELEASE OF INFORMATION

For office use only
Record faxed to: (_____)_____
Record faxed on _____ (date)
By_____ (clerk)

This is to certify that permission is hereby granted to release information as follows:

Information to be **released for** _____ _____
Name of patient (LAST NAME, FIRST NAME) Date of Birth

Information to be **released by:** ☐ Washoe County Health District ☐ Other _____ (____) _____
Name of Physician, Clinic, Agency, Other Fax number

Information to be **released to** _____ (_____) _____
Name of person, physician, clinic, agency, other Fax number

Address to send record _____
Address City State Zip

This protected health information is being released for the following purpose:

☐ Treatment ☐ Payment ☐ At the request of the individual ☐ Other_____

Information to be released: Dates of service to be included: _____

Type(s) of service provided: _____

Information released: ☐ Nurses notes ☐ Doctors orders ☐ Other_____
☐ Lab/Diagnostic tests ☐ Entire patient record (including records from other health care providers)

INFORMED CONSENT

By signing below, I understand that:

- This Authorization form is good until _____ or until I ask in writing for it to end, whichever comes first. *(Date – 1 year maximum)*
- I have the right to stop this Authorization form by FAXing a request to the Program listed below or writing to the Washoe County Health District at 1001 E. 9TH St, Bldg. B, Reno, NV 89512.
- If I stop this Authorization form, it will not effect sharing of my health information that has already happened.
- Any information used or shared with my permission in this Authorization form may be shared by the person or place receiving the health information. Once the health information is shared, it may no longer be protected by federal or state law.
- I may refuse to sign this Authorization form, but my records cannot be shared without my signature.
- My signing or not signing of this Authorization form will not change the services I receive at the Washoe County Health District including my treatment, payment, enrollment or eligibility.
- I have a right to look at or copy the information that will be used or shared because of this Authorization form.
- If by law the Washoe County Health District cannot send the protected health information to the place listed above, please initial in the following space if you want a copy of the information sent to you directly: _____.

He leído y entendido este formulario en español. (Iniciales aquí y firma abajo por favor) _____

_____	_____	_____	_____
Date *Fecha*	Authorized Signature (Patient, Parent/Guardian, Other) *Firma (paciente, padre de familia/tutor, Otro)*	Relationship to patient *Relación al paciente*	Phone Number *Número de teléfono*

Please check the program for the records requested and FAX to that program.

☐ **Tuberculosis (TB) Clinic**
PH: 775-785-4785
FAX: 775-785-4737

☐ **STD, HIV or Family Planning**
PH: 775-328-2470
FAX: 775-785-4188

☐ **Immunization Clinic**
PH: 775-328-2402
FAX: 775-785-4189