



# TAHOE FOREST HOSPITAL DISTRICT



Tahoe Forest Hospital  
10121 Pine Avenue  
Truckee, CA 96161

HIM Fax: 530-582-1864  
HIM Email: HIMROI@tfhd.com

Incline Village Community Hospital  
880 Alder Avenue  
Incline Village, NV 89451-8215

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_

### Information to be Released From:

TFH    IVCH   Doctor's Name(s): \_\_\_\_\_

### Purpose of Requested Use or Disclosure:

Continuity of Care – Appointment Date with Physician: \_\_\_/\_\_\_/\_\_\_\_\_

Patient    Insurance    Other: \_\_\_\_\_

### Person / Organization Authorized to Receive Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Fax Number: \_\_\_\_\_

### Health Information Requested (Check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Consultation Reports   | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Progress Notes  |
| <input type="checkbox"/> Discharge Summary      | <input type="checkbox"/> Laboratory Tests     | <input type="checkbox"/> Imaging Reports |
| <input type="checkbox"/> Emergency Room Reports | <input type="checkbox"/> Procedure Reports    | <input type="checkbox"/> Images on Disc  |

All Medical Records

Billing Records

Date(s): \_\_\_\_\_

Other: \_\_\_\_\_

**Note:** Records may include information related to mental health, alcohol/drug use, and HIV/AIDS. However, treatment records from mental health and/or alcohol/drug departments and/or results of HIV tests will not be disclosed unless specifically requested below.

Mental Health Records    Alcohol/Drug Records    HIV Test Results Records

### ***Method of Delivery of Requested Records***

Mail       Pickup       Encrypted Flash Drive

Electronic Delivery Recipient Email: \_\_\_\_\_

### ***Duration / Revocation / Rediscovery***

- The authorization is effective for one year from the date of signature unless a different date is specified here: \_\_\_\_\_ (date).
- The authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.
- A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.

**Notice:** Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### ***Signature***

The undersigned authorizes the medical provider designated below to disclose specified medical records to a designated recipient. The medical provider shall not condition treatment, payment, enrollment, or eligibility for benefits on the submission of this authorization.

Patient Signature\*: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

\*If not signed by the patient, please indicate relationship to the patient (check one if applicable):

- Parent or guardian of minor patient who could not have consented to health care.
- Guardian or conservator of an incompetent patient.
- Beneficiary or personal representative of deceased patient.

**There may be fees incurred for this service.**