Renown
REGIONAL
MEDICAL CENTER
Release of Information Dept.
1155 Mill Street, Reno
Reno, NV 89502
Phone 775-982-5661
Fax 775-982-5372

To Whom It May Concern:

Please be advised that by filling out the authorization properly, it will enable us to process your request quickly and you will get exactly what you are requesting. Make sure that the following is done on the authorization. Also, be aware that there is a charge of 60 cents per page for records.

1. Please print legibly in ink.
2. If patient's name was different , or has an AKA, note that above the name.
3. Must be signed and dated by the patient (unless the patient is a minor).
4. If you are requesting for yourself, completely fill in your information.
5. Date of service (approximate if not sure of exact date).

If you are requesting records of a patient that is deceased or is unable to sign for themselves, the state requires that you must have the following information in order to receive records on their behalf:

1. A copy of a Power of Attorney, Guardianship papers, Executor of the estate, or some type of court document that allows you access to the records.
2. A copy of the Death Certificate (if deceased).

Our processing time is 7 to 10 days, excluding holidays and weekends. Thank you for taking time to correctly fill out our authorization form. This helps us to properly process your request. We also offer Record Trak. This allows you to track your request online. Please give us your e-mail address or fax number and we will automatically set you up on this feature. Once set up, you will receive an e-mail confirmation and/or fax to let you know we received your request. You may track it through all the processing stages.

Renown Health

Authorization for Release/Disclosure of Protected Health Information: *This form may be used for continuity of care; treatment, payment and health care operations (TPO); and the release of protected health information (PHI) which is not required by law. Provide a copy to the patient/patient representative when Renown Health initiates the authorization for non-TPO reasons.*

Renown entity: RRMC
Address: 1155 MILL ST.
Attn:
RENO NV 89502
PHONE: 775/982 5661
FAX: 775/982 5372

Notice to the individual making this authorization:

1. After your protected health information (PHI)/medical records are released by your authorization, the possibility exists that your PHI will no longer be subject to the protection of federal privacy regulations and may be redisclosed by the recipient.
2. You may revoke this authorization at any time in writing. Your written revocation will become effective upon receipt, but will not apply to any PHI released prior to that date or to the extent that the referenced Renown Health entity has taken action in reliance upon this authorization.
3. Renown Health will not condition treatment on whether you sign this form.

THIS AUTHORIZATION WILL EXPIRE 90 DAYS AFTER THE DATE OF SIGNATURE.

Patient Name	Date of Birth	Social Security Number
Address		Phone
City, State Zip		Fax

I authorize (you must check the blank that applies):

____ **The provider listed below to release/disclose the PHI described below to the above-referenced Renown Health entity:**

____ **The above-referenced Renown Health entity to release/disclose the PHI described below to:**

Name of Provider/Party Authorized to Receive PHI/Medical Records	
Address	Phone
City, State, Zip	Fax

Description of information to be released for the following dates of treatment/service: ____

___Physician generated data	___Discharge summary	___Diagnostic imaging	___Therapy evaluations /records
___H&P	___Discharge Instructions	___Diagnostic data	___Medication records
___Operative report/s	___ER documents	___Labs	___Consultation report/s

___Other (describe): ____

NOTE: The use or disclosure of psychotherapy notes requires a separate authorization.

Reason for this request: ____ Continuity of Care ____ Legal ____ Patient request

____ Other (describe): ____

I understand that my PHI/medical records ***may contain information about:***

- Drug and/or alcohol abuse history, diagnosis, treatment;
- Psychiatric history, diagnosis, treatment;
- AIDS/HIV, sexually transmitted diseases, hepatitis and/or other infectious disease history, diagnosis, treatment.

By signing below, I authorize the release/disclosure of my PHI even if it contains information regarding the above-listed types of information within the PHI/medical records requested.

Signature of patient or personal representative	Date
Print name of personal representative	Representative's authority

For Renown Health Personnel Use Only:

Renown Patient Medical Record No.