AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This Authorization grants permission to release protected health information pursuant to 45 C.F.R. Parts 160 and 164, as follows:

Information to be released _____,_____ ,_____.
Name DOB Address

Information to be released by _____.
Medical Provider Name

Information to be released to Douglas County District Attorney's Office, P.O. Box 218, Minden NV 89423. Disclosure may be made orally or in writing and the Provider is authorized to photocopy records.

This protected health information is being released at the request of the patient.

Information to be released: Date(s) of service included_____

Type(s) of service provided_____

Types of information:
- ☐ Nurse's notes ☐ Doctor's orders
- ☐ Lab/diagnostic tests, including blood, breath or urine test results
- ☐ Communicable disease information, including sexually transmitted disease information
- ☐ Information about mental health treatment I have sought and /or received
- X Entire record (including records from other health care providers)

I acknowledge: i) that I have the right to revoke this authorization at any time, and ii) that I understand that once the protected health information is disclosed hereunder, it may no longer be protected by federal privacy law. I understand that I may revoke this authorization only in a writing sent by certified mail to the Provider at the address set forth above. The revocation will be effective only upon receipt, except to the extent the Provider has acted in reliance upon the authorization. Further information on the right to revoke may be provided from time to time in the Provider's Notice of Privacy Practices.

I understand that treatment by the Provider is not conditioned on my signing this authorization, although exceptions will be made i) for research-related treatment, ii) for treatment the purpose of which is creating protected health information for a third-party, and iii) except for psychotherapy notes, for health plans which condition enrollment on an authorization requested prior to enrollments, or where payment is conditioned on an authorization to use the protected health information to determine payment.

This consent is valid for one year from the date this authorization is signed.

_____ _____
Date Signed by:

If the person signing the authorization is someone other than the subject of the records, state authority under which signature is made:

_____