NNAC AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

	Initial here if requesting information from NORTHERN NEVADA ALLERGY CLINIC **Note:** There will be a charge of $.60 per page (first 10 pages at no cost) if source document is paper for releases of PHI for all reasons other than continued patient care.
	Initial here if requesting to have records sent from another Facility to Northern Nevada Allergy Clinic.
	Initial here if requesting access to review original medical records.

Patient Name at Time of Treatment | **Date of Birth** | **Social Security Number**

Street Address | **Home Phone Number**

City | **State** | **Zip Code** | **Work Phone Number**

Email _____

This document authorizes Northern Nevada Allergy Clinic to use and disclose Protected Health Information (PHI) as described below. Uses and disclosures of PHI will be consistent with Nevada and Federal law concerning the privacy of PHI. **Failure to provide all information requested will delay action on this Authorization.**

1. ***Person(s)/Organization(s) authorized to receive the PHI:*** ❑ **Northern Nevada Allergy Clinic Fax: 775-826-3257**

2. ***Purpose of Requested Use or Disclosure:***

3. ***Description of the information included in Use or Disclosure:*** ***Treatment date(s):*** _____ ***to*** _____
   - ❑ Billing Record
   - ❑ All PHI In Medical Record (Complete Chart Copy)
   - ❑ Radiology Images
   - ❑ History and Physical
   - ❑ Operative Report
   - ❑ X-Ray Report
   - ❑ Lab Reports/Pathology Reports
   - ❑ Other (please specify): _____

4. ***By signing my initials next to the specific category of highly confidential information, I am authorizing Northern Nevada Allergy Clinic to release the indicated type of information next to my initials pursuant to this Authorization from the treatment date(s) listed above.***
   _____ HIV/AIDS _____ Drug and Alcohol Information _____ Genetic Information
   _____ Mental Health Information _____ Sexually Transmitted Disease Information _____ Tuberculosis Information

5. ***Please list a date or event at which point this Authorization will expire (not to exceed 1 year):***

NOTICE OF RIGHTS AND OTHER INFORMATION:

1. I understand that I have the right to revoke this authorization at any time. Such requests must be submitted in writing to the attention of **8610 Technology Way, Reno NV 89521** or **3086 Silver Sage Drive, Carson City, NV 89701**. Cancellation of my authorization will be effective when Northern Nevada Allergy Clinic receives my signed request, but it will not apply to the information that was used or disclosed prior to that date.
2. I understand that refusal to sign this authorization will have no effect on my enrollment, eligibility for benefits, or the amount a third party payor pays for the health services I receive.
3. I understand that the person or entity that receives this information may not be covered by the federal privacy regulations, in which case the information above may be redisclosed and no longer protected by these regulations. I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for the use and/or disclosure.
4. I have a right to receive a copy of this authorization. I may inspect or obtain a copy of the protected health information that I am being asked to use or disclose.

Signature of Patient | **Date**

Signature of Legal Representative | **Print Name** | **Date** | **Relationship To Patient**

Witness | **Date**

Reason Patient Unable to Sign

❑ **I Will Pick Up PHI**
❑ **Mail PHI**
❑ **Please Fax PHI To Physician Indicated**

❑ **Patient received copy of authorization** **Staff Initials:** _____

Instructions for completing the

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

IMPORTANT INFORMATION

» The *Authorization To Use And Disclose Protected Health Information* form must be filled out in its entirety. Failure to properly complete the form will result in a delay in processing your request.
» In accordance with 45 C.F.R. § 164.524, copies of your medical records will be provided to you within 30 days.
» Copies of **incomplete** medical records will not be released for purposes **other than** continued patient care.
» Copies ***cannot*** be faxed to a private residence. They can only be faxed to the place of business of another health care provider.
» ***There will be a charge of $.60 per page (first 10 pages at no cost) if source document is paper for releases of PHI for all reasons other than continued patient care.***
» In accordance with **NRS 629.061.1**, the following is the practice policy for requesting medical records for a deceased patient:
1. When requesting medical records for a deceased patient, one of the following must be presented:

Handwritten will – A handwritten will is valid in Nevada if there is a sole beneficiary and it is signed and dated by the decedent. No witness or notary signature/stamp is required. It is assumed (and accepted) that the sole beneficiary is Executor. A non-interested third party must sign an affidavit stating that the signature of the decedent is authentic.
Regular will – This must state that the decedent was in sound mind, over 18 and not under duress at the time of the will's creating. It must be witnessed by two other people and notarized to be "self-proving"(i.e. valid).
Special Letter of Administration – A special letter of administration can be issued by Probate specifically to authorize an individual to obtain the medical record of the decedent provided that there are no assets in the estate. This process has no cost and takes two days.
Probate: If there is no valid will, the petitioner must request a hearing with Probate to be named Executor. It generally takes 2-3 weeks from the time of the application to the actual hearing. You must contact the office of the Probate Court for additional information.

Address: Probate Specialist, 75 Court Street #125, Reno, NV 89501 Phone: 775-328-3100

INSTRUCTIONS:

In the boxes at the top of the form:

- Initial the first box if you are requesting records. This includes any request to disclose records to another health care provider (continued patient care).
- Initial the second box if you are requesting to have records sent from another facility (hospital, clinic, physician's office, surgery center, etc.) ***to*** our practice.
- Initial the third box if you are requesting to view original medical records at our practice. You will be supervised while you review original medical records.

Indicate the following:

- **Patient's** name at the time of treatment, date of birth, Social Security Number.
- Home and work telephone numbers and street address of patient (requestor), or the address to which records are to be mailed.

In the Black Box in the middle of the form, please indicate the following:

1. Indicate the Person(s)/Organization authorized to ***release*** the records. If you are requesting records **from our practice** check the box. If you are requesting records from another hospital, clinic, physician's office, surgery center, etc., indicate the name, address, telephone number and fax number of that physician or health care provider.
2. Indicate the Person(s)/Organization authorized to ***receive*** the records. If you are requesting records to be **sent to** our practice check the box. If you are requesting that we send records to another hospital, clinic, physician's office, surgery center, etc., indicate the name, address, telephone number and fax number of that physician or health care provider.
3. Indicate the purpose of the disclosure (e.g. continued patient care, personal use, Attorney).
4. Provide a description of the specific records to be copied or sent:
   - Provide the most accurate treatment dates possible.
   - Check the box(es) next to the corresponding type(s) of documentation you are requesting (more than one may apply).
5. Place your initials next to the specific category of highly confidential information to be disclosed. ***Failure to initial next to these items prohibits disclosure of that PHI, and may delay the processing of your request.***
6. List a date or event at which point this Authorization will expire. This date or event is not to exceed one year from the date of the request.

- Sign and date the Authorization to validate it and set it into motion. Unsigned Authorization forms **will not** be honored.
- If the patient is unable to sign (or is a minor), the reason must be indicated and the Legal Representative for that patient must print and sign his or her name, date the form, and indicate his or her relationship to the patient. When applicable, appropriate Power Of Attorney or Probate documentation must accompany the Authorization.
- Indicate by checking the appropriate box whether the PHI is to be mailed, picked up from our office or faxed.