HIPAA COMPLIANT AUTHORIZATION FOR USE AND DISCLOSE OF PROTECTED HEALTH INFORMATION

*This document allows **Silver Sage Center for Family Medicine**, or its authorized representatives to use and disclose Protected Health Information (PHI) as described below. Uses and disclosures of PHI will be consistent with Nevada and Federal laws concerning the privacy of PHI and HIPAA (45cfr164.508). Please send all requested documents to Fax # **775-853-3339/775-853-2306, or by mail, to 10467 Double R Blvd, Reno, NV 89521.***

PATIENT NAME: ________________________________ DOB: ____________SSN: ______________

ADDRESS: ____

I authorize SSCFM to Obtain Records From:

____

Address: __________________________

Ph: _________________ Fax: _____________

I authorize SSCFM to Obtain Records From:

____

Address: ______________________________

Ph: ________________ Fax: _____________

Expiration of disclosure: ______________(Authorization expires 1 year after signing unless otherwise specified)

Type of information to be disclosed:

☐All Medical Records ☐Therapy Notes ☐Diagnostic Report (Labs, EEG, X-Ray, etc.)
☐All Progress Notes ☐Medical Progress Notes ☐Substance/Alcohol use diagnoses, treatment
☐Medication Records ☐Medical Assessment ☐HIV/AIDS Status
☐Attendance Record ☐Psychiatric Progress Notes ☐Discharge Summary
☐Psychiatric Assessment ☐Immunization Record

Notice of rights and other information:

I may refuse to sign this authorization. I understand that the person or entity that received this information may not be covered by the federal privacy regulations; in that case, the information described above may be disclosed again and longer protected by these regulations. I may cancel this authorization at any time. I must give written notice of such cancellation and the notice must be signed by me (or on my behalf) and delivered to Silver Sage Center for Family Medicine or its authorized representative. Cancellation of this authorization will not apply to information disclosed prior to the date of cancellation. I have a right to receive a copy of this authorization and one will be furnished upon my request. I have a right to receive a copy of the health information I am asking to disclose. I acknowledge that I have read this authorization, that the terms have been explained to me, that I understand all of the terms and I am competent to sign this authorization for myself or that I am authorized as a parent, guardian or legal representative to sign for the patient named above.

Patient Signature____ Date___________

Parent/Guardian/Legal Representative______________________ Relationship to Patient____________

Date_____________