Tahoe Forest Hospital District
Tahoe Forest Hospital
10121 Pine Avenue
Truckee, CA 96161
HIM Fax: 530-582-1864
HIM Email: HIMROI@tfhd.com

TAHOE FOREST HOSPITAL DISTRICT

Incline Village Community Hospital
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)

❑ Consultation Reports ❑ History and Physical ❑ Progress Notes
❑ Discharge Summary ❑ Laboratory Tests ❑ Imaging Reports
❑ Emergency Room Reports ❑ Procedure Reports ❑ Images on USB
❑ All Medical Records **❑ Billing Records** ❑ Images Via The Cloud

❑ 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

Distribution: White copy - HIM Department, Yellow copy - Customer copy

Method of Delivery of Requested Records

❑ Mail ❑ Pickup ❑ Encrypted Flash Drive

❑ Electronic Delivery Recipient Email: _____

Duration / Revocation / Redisclosure

- 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.