



# Touro University Nevada

## Center for Autism and Developmental Disabilities

874 American Pacific Drive / Henderson NV 89014 / T 702.777.4808 / F 702-777-4818 / tun.touro.edu

### Authorization to Release Patient Health Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I request and authorize the release of healthcare information of the patient named above:

<b>Send Records <input type="checkbox"/> TO / <input type="checkbox"/> FROM:</b> T.U.N. Center for Autism & Developmental Disabilities 874 American Pacific Drive Henderson, NV 89014 (702) 777-4808 phone * (702) 777-4818 fax	<b>Send Records <input type="checkbox"/> TO / <input type="checkbox"/> FROM:</b> Facility/Attn: _____ Address: _____ Phone: _____ Fax: _____
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*Type of Information to be released (limited to 2 years of information, unless otherwise stated):*

1. **General Release:** FROM: \_\_\_\_\_ TO: \_\_\_\_\_  
 Entire Records  Provider Notes  Diagnostic Tests  Lab Results  Immunizations  Other  
 Notes: \_\_\_\_\_

2. **Information Protected by State / Federal Law:** FROM: \_\_\_\_\_ TO: \_\_\_\_\_  
 Diagnosis  Treatment OF:  STD(includes HIV/AIDS)  Substance Abuse/Addiction  Mental Health /Psychiatric  
 Genetic Tests  Child & Domestic Abuse History  Other: \_\_\_\_\_  
 Notes: \_\_\_\_\_

3. **Patients Right to Revoke:** I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the HIPAA Privacy Office. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:  
 \_\_\_\_\_ **IF LEFT BLANK, THIS AUTHORIZATION WILL EXPIRE IN TWELVE MONTHS.**

4. **Redisclosure:** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the health Information Management Department and obtain a copy of the Privacy Notes.

**The recipient may use the health information authorized on this form for the following purposes:**  
 Patient is transferring care  Insurance Obligations  Personal  
 Needed for Medical Care  Legal Purposes  Other: \_\_\_\_\_

**\*\*NOTE: There is a charge of 60 cents per page unless information is being disclosed to a medical facility.  
 PLEASE ALLOW 7-10 BUSINESS DAYS FOR PROCESSING.**

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative Date

\_\_\_\_\_  
 Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient