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:

Send Records ❑TO / ❑FROM:	**Send Records ❑TO / ❑FROM:**
T.U.N. Center for Autism & Developmental Disabilities 874 American Pacific Drive Henderson, NV 89014 (702) 777-4808 *phone* * (702) 777-4818 *fax*	Facility/Attn: _____ Address: _____ _____ Phone: _____ Fax: _____

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 t hat 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**