Tahoe Forest Hospital District
Tahoe Forest Hospital
10121 Pine Avenue
Truckee, CA 96161

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

Print Name of Patient _____ Previous Names, if Applicable _____

Address _____ Date of Birth _____

City / State / Zip Code _____ Day time Telephone Number _____

SEND INFORMATION TO: (please be specific)

Provider Name / Organization: _____

Address: _____

_____

Telephone#: _____ Fax#: _____

INFORMATION TO BE RELEASED FROM:

Provider Name/Organization: _____

Telephone#: _____ Fax#: _____

PURPOSE OF DISCLOSURE:

☐ Continuing Care ☐ Self ☐ Other _____ (must complete)

INFORMATION TO BE DISCLOSED:

Dates of Service: _____

☐ Clinical Summary
☐ History & Physical
☐ Consultation Report
☐ Operative Report
☐ Entire Record
☐ Laboratory Reports: _____
☐ Pathology Report
☐ Radiology Reports: _____
☐ Emergency Room Report
☐ Other (Please specify): _____

8700-1000-A (10/10)

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If the patient is unable to sign, please indicate the name of the authorized individual who is signing for the patient. This form must be dated within 60 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions on how to revoke this authorization. Completion of this authorization will not affect your medical care or treatment. Please be advised that once we disclose information per your request, the information is subject to re-disclosure and may no longer be protected by the 1996 HIPAA law.

This Authorization Expires: _____

Patient Signature: _____

Date: _____ Time: _____

Authorized Representative Signature: _____

If signed by someone other than the patient, state your relationship to the patient:

Proof of this relationship: _____

Custodian Releasing Records: _____

THIS SPACE INTENTIONALLY LEFT BLANK

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NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this Authorization
- I may revoke this authorization at any time. My revocation must be in writing,signed by me or on my behalf and delivered to the following address:

Tahoe Forest Hospital District
c/o Medical Records
P.O. Box 759
Truckee, CA 96160

- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this authorization
- Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained for me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose
- If this box ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information.

8700-1000-A (10/10)