

University of Nevada, Reno  
Student Health Center  
Redfield Bldg. Mail Stop 196  
Reno, NV 89557

Medical Records Department  
Phone: (775) 784-6598  
Fax: (775) 784-1298

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

Patient Name (please print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Phone #: \_\_\_\_\_

**For Records Leaving UNR Student Health Center**

I authorize UNR Student Health to release my medical records to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**For Records Coming to UNR Student Health Center**

I authorize :

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

To release my records to:

UNR - Student Health Center  
Redfield Bldg. Mail Stop 196  
Reno, NV 89557  
(775) 784-6598 Phone  
(775) 784-1298 Fax

**I authorize the following information to be disclosed:**

- Immunizations
- Lab
- X-ray
- Complete Medical Record
- HIV test results (*Specify*)  Yes  No
- Mental Health/Counseling  Yes  No
- Other *specify*) \_\_\_\_\_

**For the purpose of: (check one):**

- Continuity of Care
- Consultation
- School Transfer
- Personal
- Insurance
- At my request
- Other

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken. This authorization will expire 90 days from date of signature and I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. The University, Provider, and its employees, officers, and healthcare providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized. A copying fee of \$.60 per page applies to my request per **NRS 629.061**.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative

\_\_\_\_\_  
Relationship

.....  
**Official Use Only:** Release Date/Initials \_\_\_\_\_ / \_\_\_\_\_

Release Method:  Mail  Fax # ( ) \_\_\_\_\_  Hand carry Date \_\_\_\_\_

Payment Method:  N/C  Cash  Check # \_\_\_\_\_

**Recipients of Alcohol/Drug/Infectious Disease/Mental Health Records:** This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2) and state law. These laws prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or state law. A general authorization for the release of medical information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.