AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION ("Authorization")
NOTE: ALL sections must be completed

Patient Name: _____ Birth Date: _____
Printed (First) (MI) (Last Name)
Address: _____ Telephone #: _____
Street Address City State Zip Code

I authorize: Renown Health to *(circle one)* SEND TO *-or-* RECEIVE FROM the below entity:

Records Deposition Service Telephone #: (248) 357-3330 Fax: (248) 357-3337
Full Name/Entity
Address: 29100 Northwestern Hwy., Ste. 300 Southfield MI 48034
Street Address City State Zip Code

Purpose of Request to Release:
□ Treatment □ Personal/Patient Request ☑ Legal/Attorney □ Insurance □ Other (*specify*):
_____

For Date(s) of Service from: _____ to _____ [Dates MUST be specified]

Information To Be Disclosed:
□ Admission History & Physical □ Emergency Room Records □ Consultations □ Operative Reports
□ Progress Notes □ Radiology & X-Ray Reports □ Laboratory Reports □ Discharge Summary
□ Entire Medical Record (Does not include billing or Radiology Films/CDs) □ Other:: _____

Additional Information To Be Disclosed:
□ Billing Records
□ Radiology Films/CDs

I Specifically Authorize Release of These Records (these records will NOT be released unless you initial & check the box to consent to release):
Initial: _____ □ Release Drug, Alcohol & Substance Abuse Records
Initial: _____ □ Release Communicable Disease Records, including without limitation, HIV/AIDS Records
Initial: _____ □ Release Genetic Testing Records
Initial: _____ □ Release Psychiatric & Mental Health/Behavioral Health Records. Treating provider approval is required for release of Psychiatric & Mental Health/Behavioral Health Records.

I UNDERSTAND THAT:
- This Authorization will become effective immediately and will expire on _____ [*Date*]. If no date is specified, this authorization will expire one (1) year from the signature date.
- I may revoke this Authorization at any time, in a written revocation sent to the Custodian of Records. However, I understand that my health information might have already been released.
- Information released by this Authorization might be re-disclosed by the recipient and might not be protected by state and federal privacy laws. I agree to release Renown Health from liability for release and disclosure of the released information.
- I am not required to sign this Authorization as a condition to obtain treatment, services or for eligibility of benefits. My signature on this Authorization is voluntary.

Signature of PATIENT ONLY: _____ Print Name:_____ Date: _____

Signature of Person Who Is NOT the Patient: _____ Date: _____
Print Name: _____ Authority to Sign: _____
Proof of Authority MUST be attached (except for parents)
Address: _____ Tel No: _____

***Completed by Staff Member Fulfilling & Verifying Authorization & Completeness ***
Date: _____ Time: _____ Verified By: _____

MR #: _____ Account #: _____
List Document Used to Verify (attach a copy): _____
Provider Signature for Release of Psychiatric/Mental Health Records: _____
Printed Provider Name: _____ Date: _____

Renown HEALTH

Renown Regional
Medical Center
1155 Mill St. MS O12
Reno, NV 89502
Fax: 775-982-3759

ROI
Authorization

□ Tracking only/Records released
□ Mail
□ Pa. ent Pick-up at Harvard Way