AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This is not a Durable Power of Attorney for Health Care Decisions.

This decision is voluntary. The information you authorize us to disclose may be subject to re-disclosure by the recipient, and if the person or organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by the Federal privacy regulations.

You have the right to revoke any written authorization, except to the extent that we have taken action in reliance on the authorization, by writing to us at: NEVADA HEALTH CO-OP, in Receivership, 840 S. Rancho Drive #4-321, Las Vegas, Nevada 89106. We may not condition your receipt of treatment, payment, enrollment, or eligibility for benefits upon completion of this authorization.

ALL FIELDS MUST BE COMPLETED. See instructions on reverse side.
(Please Type or Print)

1. **Member Number**: _____

2. **Member Name** (one member per form): _____

3. **I authorize Nevada Health CO-OP to disclose my Protected Health Information as designated in #4 below to the following person or organization**:

   Name of Individual or entity: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Phone: _____ Fax: _____

***Information pertaining to substance abuse diagnosis or treatment requires completion of the Consent for Release of Confidential Health Information under rules (42 C.F.R. Part 2)—Confidentiality of Alcohol and Drug Abuse Patient Records.**

4. **I authorize Nevada Health CO-OP to disclose:**
   Information regarding eligibility, benefits, claim adjudication, prior authorization status, primary care provider information, and medical records, **AND/OR**
   The following specific information*: _____
   _____
   _____

5. **Purpose of the disclosure: I understand that the information designated in #4 above is being disclosed at my request.**

6. **This authorization shall remain in effect from the date signed below until** (check only one):

   ☐ One year from the date this authorization is signed
   ☐ Specific expiration date (MM/DD/YY): _____
   ☐ Once the following event occurs: _____

7. **Member's Signature:** _____ **Date:** _____
   Personal Representative's Signature: _____ Date: _____
   (Complete if the member is a minor and if no sensitive health information is being disclosed, or if the member is legally incapacitated)

   _____ _____
   Print Name Relationship to Member

   Legal Authority: _____

Documentation of The Personal Representative's Legal Authority Must Be Attached

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

INSTRUCTION SHEET

The numbers on this instruction sheet directly correspond to the numbers on the authorization form (*i.e.*, 1 on this sheet provides instruction on how to fill out line 1. on the authorization form).

1. Please print legibly, your full name (first name, last name). Enter only one member name per form.

2. Write in your 11-digit identification number (may be called the Member or Medical Identification on your ID card). Enter only one member number per form.

3. Write in the name of the person or organization you authorize us to disclose this information. Please include the full name (*e.g.* first name, last name) and address of the individual or organization, and please print legibly.

4. You must specify what information you want Nevada Health CO-OP to disclose. You can check the first box for information regarding eligibility, benefits, claims adjudication, prior authorization status, and primary care physician assignment, **AND/OR** you can indicate other information you want disclosed by checking the second box and writing the specific information in the space provided. You may choose one or both options.

   Information pertaining to substance abuse diagnosis or treatment is protected by Federal confidentiality rules (42 C.F.R. Part 2). Disclosure of such information requires completion of the Consent for Release of Confidential Health Information under rules (42 C.F.R. Part 2)—Confidentiality of Alcohol and Drug Abuse Patient Records.

5. By signing this authorization, you certify that you understand that this information is being disclosed at your request.

6. You have a choice of how long the authorization remains in effect. Please select *only one* option. If you select a specific expiration date or event, you must include additional details such as the specific date (*e.g.*, 12/31/2008 or 01/01/2999) or specific event (*e.g.*, until I am released from my inpatient stay at St. Rose Hospital). **Please note the following are examples of unacceptable expiration dates: "No expiration date," "Forever," and/or "Infinity."**

7. The signature of the individual member and date are required. If the authorization form is signed by a personal representative for the member, the personal representative must provide legal documentation that he/she is authorized to act on the member's behalf.

ALL FIELDS MUST BE COMPLETED. An incomplete authorization form is therefore invalid and will not be accepted. If you need additional assistance filling out this form or have any questions, please call the telephone number on the back of your ID card.