HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

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

Health Plan of Nevada, Inc.
Attn. Member Services Department
P. O. Box 15645
Las Vegas, NV 89114-5645

We may not condition your receipt of treatment, payment, enrollment, or eligibility for benefits on completion of this authorization.

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 middle 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 health plan ID card, example 999999999-00). Enter only one member number per form.

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

#4. You must specify what information you want HPN 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 can 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 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 (i.e., 12/31/2008 or 01/01/2999) or specific event (i.e., until I am released from my inpatient stay at Valley 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 is required. If the authorization form is signed by a personal representative of the member, the personal representative must provide legal documentation that he/she is authorized to act on the member’s behalf.

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ALL FIELDS MUST BE COMPLETED. PLEASE PRINT CLEARLY. ONE MEMBER PER FORM.

See complete instructions.

1. **Member Name**:
   (First MI Last) _____

2. **Member ID Number**: _____

3. **I authorize Health Plan of Nevada, Inc. ("HPN"), on behalf of itself and affiliated companies, to disclose my Protected Health Information designated in #4 below to the following person or organization:**

   Name of individual or entity: _____

   _____
   Address City State Zip Code

   _____ _____ _____
   Home (xxx-xxx-xxxx) Mobile (xxx-xxx-xxxx) Fax (xxx-xxx-xxxx)

4. **I authorize HPN, on behalf of itself and affiliated companies, to disclose:**

   ☐ Information regarding eligibility, benefits, claim adjudication, prior authorization status and primary care physician assignment AND/OR

   ☐ The following specific information*:

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

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):

   ☐ Date of my disenrollment from the health plan

   ☐ One year from the date this authorization is signed

   ☐ Specific expiration date (MM/DD/YYYY): _____

   ☐ Once the following event occurs: _____

7. **Member's Signature**: _____ **Date**: _____

   Personal Representative's signature: _____ **Date:** _____
   (if member is a minor and 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.

ALL FIELDS MUST BE COMPLETED. An incomplete authorization form is invalid and will not be accepted. If you need additional assistance filling out the form or have any questions, please call Member Services. Member Services phone number can be found on the back of your health plan ID card.