



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

MEMBER AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(This authorization is not a Durable Power of Attorney for Health Care)

This authorization is voluntary and you may refuse to sign this authorization. The information you authorize us to disclose may be re-disclosed by the recipient as the information may no longer be protected under the HIPAA Privacy Rule.

An instruction sheet for completing this form appears on the back.

1. I hereby authorize Health Plan of Nevada (HPN) to use or disclose my Protected Health information designated in #2 below to the following person(s):

Horizontal line for item 1

2. [] I allow HPN to disclose information regarding eligibility, benefits, claim adjudication, prior authorization status and primary care physician assignment.

AND/OR

[] I allow HPN to disclose the following specific information:

Horizontal line for item 2

3. This information designated in #2 can be used/disclosed for the following purpose(s):

Horizontal line for item 3

4. 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
[] I request a specific expiration date (for example MM/DD/YY or claim is processed)

Provide specific detail here: _____

5. Member Name: _____
(Please print)

6. Member Number: _____

7. Member Signature: _____ Date: _____

If member is unable to sign, signature of member's personal representative is required.
Signature of member's legally authorized representative (signers other than the member must present legal documentation that {for example, Durable Power of Attorney for Health Care, Guardianship} authorizes them to act on the member's behalf).
Member's Representative Signature: _____ Date: _____
Printed name of member's representative Relationship to member

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, Attn. Member Services Department, P. O. Box 15645, Las Vegas, NV 89114-5645. Health Plan of Nevada may not condition your receipt of treatment, payment, enrollment, or eligibility for benefits on completion of this authorization.

P.O. Box 15645, Las Vegas, Nevada 89114-5645

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INSTRUCTION SHEET

This authorization is voluntary and you may refuse to sign this authorization. The information you authorize us to disclose may be re-disclosed by the recipient as the information may no longer be protected under the HIPAA Privacy Rule.

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 PHI form).

- #1 Write in the name of the person(s) or entity you authorize us to disclose this information to. Please include the full name (first name, last name) and print legibly.
- #2 You have a choice in what information you want disclosed. You can check the box to disclose information regarding eligibility, benefits, claims adjudication, prior authorization status and primary care physician assignment
- OR**
- You can limit the information that is disclosed by checking the box and writing the specific information you would like disclosed on line #2.
- OR**
- You can check both boxes and specify what information can be disclosed on the line.
- #3 State the purpose or reason this information is to be disclosed: A purpose is a core element of a valid authorization and is needed to release information to a third party. For example: "To assist with questions about my health coverage" or "Because I need assistance with claims".
- #4 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".
- #5 Please print legibly, your full name (first name, last name).
- #6 Write in your 11-digit identification number (may be called the Member # or Medical Identification # on your ID card). *This field must be completed.
- #7 A valid authorization form must contain a signature and date. The signature of the individual member and date is required. If the form is signed by a personal representative of the member, the personal representative must provide legal documentation that they are authorized to act on the member's behalf.

****PLEASE REMEMBER TO KEEP THE YELLOW COPY****

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 ID card.