AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Recipient's Name: _____

Medicaid/Nevada Check Up ID #: _____

Effective Date: _____

I hereby authorize the use or disclosure of my protected health information as described below. I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal privacy regulations.

1. Specific information that may be used/disclosed: _____
   _____
   _____
   _____

2. Information will be used/disclosed for the following purpose(s): _____
   _____
   _____
   _____

3. Persons/organizations authorized to use or disclose the information: _____
   _____
   _____
   _____

4. Persons/organizations authorized to receive the information: _____
   _____
   _____
   _____

5. The person/organization authorized to use/disclose the information will receive compensation for doing so. Yes____ No____

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 on this form.

7. If the purpose of this authorization is for the Division of Health Care Financing and Policy (DHCFP) to determine eligibility before enrollment, the requested use or disclosure is not for psychotherapy notes, and I refuse to sign this authorization, DHCFP reserves the right to deny enrollment or eligibility for benefits.

8. I understand that I may inspect or copy the information used or disclosed.

9. I understand that I may revoke this authorization at any time by notifying DHCFP in writing, except to the extent that:

    a) Action has already been taken as a result of this authorization; or

    b) If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

10. I understand that I have a right to request and receive a Notice of Privacy Practices from DHCFP.

11. This authorization expires on [upon] _____
[INSERT APPLICABLE DATE OR EVENT]

_____	_____
Signature of Recipient or Personal Representative	Date
_____	_____
Printed Name of Recipient or Personal Representative	Relationship to Recipient or Authority to Act on Their Behalf