

Division of Health Care Financing and Policy (DHCFP)

Aging and Disabilities Services Division (ADSD)

Designated Representative Attestation

Authorization for the Use and Disclosure of Protected Health Information

Recipient Printed Name: _____

Medicaid #: _____

I name the person noted below as my designated representative to act on my behalf, including signing forms and receiving information about my care. This attestation does not, in any way, limit my rights provided under the program. This attestation does not take the place of documents authorizing court ordered legal representation (i.e. Power of Attorney, private or public guardianship).

Please note: This attestation does not grant the designated representative the right to make medical decisions for the recipient or to direct the recipient's care, only to facilitate information sharing.

Designated Representative Printed Name: _____

I hereby authorize the use or disclosure of my protected health information by the State of Nevada, Department of Health and Human Services, the Division of Health Care Financing & Policy (DHCFP) and Aging and Disabilities Services Division (ADSD) as described below to the above named Designated Representative. I understand the following:

- The information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.
- This authorization is voluntary and I may refuse to sign it. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or the ability to obtain treatment, except if the purpose of this authorization is for the DHCFP and ADSD to determine eligibility before enrollment; the DHCFP and ADSD reserves the right to deny enrollment or eligibility for benefits.
- I may inspect or copy the information used or disclosed.
- I may revoke this authorization at any time by notifying the DHCFP or ADSD in writing, except to the extent that action has already been taken as a result of this authorization.

Specific information that may be used/disclosed:

Waiver Eligibility
Date range: _____

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

Waiver Eligibility

The person/organization authorized to use/disclose the information will receive compensation for doing so:

- Yes
- No

This authorization expires on (upon) _____

[insert applicable date or event]

If no date is listed above, this attestation is valid and in effect until I provide written notice to the DHCFP or ADSD that I no longer wish this individual to represent me.

I release the DHCFP and ADSD from any liability resulting from authorized disclosure of information to my designated representative. A copy of this attestation can serve as an original.

I wish to appoint the above designated representative:

Recipient unable to sign due to physical or cognitive limitations

Recipient Signature: _____

Designated Representative Signature: _____

State Worker Printed Name: _____

State Worker Witnessing Signature: _____

Date: _____

I wish to remove the above designated representative:

Recipient unable to sign due to physical or cognitive limitations

Recipient Signature: _____

State Worker Printed Name: _____

State Worker Witnessing Signature: _____

Date: _____

For DHCFP/ADSD staff use only:

In the professional judgment of the State Worker, it has been determined that the recipient agrees to have the above named designated representative and requires this representation due to the following reason(s):

The relationship between the recipient and designated representative: _____