Authorization for the Use and Disclosure of Protected Health Information

Recipient's Name: ______________________________

Medicaid/Nevada Check Up ID #: ______________________________

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

- The information I authorize a person or entity to receive may be redisclosed 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 to determine eligibility before enrollment; the DHCFP 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 in writing, except to the extent that action has already been taken as a result of this authorization.

Persons/organizations authorized to receive the information: ______________________________
____
____

Specific information that may be used/disclosed:
- ☐ Billing records
- ☐ My entire file
- ☐ Other: ______________________________

Date range: ______________________________

Information will be used/disclosed for the following purpose(s):
- ☐ Legal reasons
- ☐ Further medical care
- ☐ At my request

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]

______________________________ ______________________________
Signature of Recipient or Personal Representative Date

______________________________ ______________________________
Printed Name of Recipient or Personal Representative Relationship to Recipient or Authority to Act on Their Behalf