HOMETOWN HEALTH AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION ("HIPAA Authorization Form")

NOTE: ALL sections must be completed

Member Name: _____ Birth Date: _____
Printed (First) (MI) (Last Name)
Address: _____ Telephone #: _____
Street Address City State Zip Code

I authorize my health plan: Hometown Health, 10315 Professional Circle, Reno, NV 89521 to use and/or disclose my health and medical Information, as specifically described below:

Release Information To:_____ Telephone #: _____ Relationship to member : _____
Full Name/Entity
Address: _____
Street Address City State Zip Code

Purpose of Request to Release:
□ Treatment □ Payment □ Personal/Member Request □ Legal/Attorney □ Insurance
□ Other (*specify*): _____

For Date(s) of Service from: _____ **to** _____**Dates [MUST be specified]**

Information To Be Disclosed:
□ Explanation of Benefits (EOB) □ Referral/Authorization □ Medical Assessment Forms □ Claims
□ Enrollment Form □ Certificate of Creditable Coverage □ Premium Payment Records □ Case Management Notes
□ Appeal Information □ Medical Records related to specific appeal(s), denial(s), incident or event maintained by Hometown Health □ Other: _____

I Specifically Authorize Release of These Records (these records will NOT be released unless you <u>initial & check the box</u> to consent to release):
Initial: _____ □ Release Drug, Alcohol & Substance Abuse Records
Initial: _____ □ Release Communicable Disease Records, including without limitation, HIV/AIDS Records
Initial: _____ □ Release Genetic Testing Records
Initial: _____ □ Release Psychiatric & Mental Health/Behavioral Health Records. **Psychotherapy Records will NOT be released. Release of Psychotherapy Records requires a separate release form**. Treating physician approval is required for release of Psychiatric & Mental Health/Behavioral Health Records.

I UNDERSTAND THAT:
● This Authorization will become effective immediately and will expire on _____ [*Date*]. If no date is specified, this authorization will expire one (1) year from the signature date.
● I may revoke this Authorization at any time, in a written revocation sent to the Custodian of Records. However, I understand that my health information might have already been released.
● Information released by this Authorization might be re-disclosed by the recipient and might not be protected by state and federal privacy laws. I agree to release Renown Health from liability for release and disclosure of the released information.
● I am not required to sign this Authorization as a condition to obtain treatment, services or for eligibility of benefits. My signature on this Authorization is voluntary.

Signature of MEMBER ONLY: _____Print Name: _____ Date: _____

Signature of Member's Personal Representative (if member is unable to sign): _____ Date: _____
Print Name: _____ **Authority to Sign**: _____
Proof of Authority MUST be attached (except for parents)
Address: _____ Tel No: _____

***Completed by Staff Member Fulfilling & Verifying Authorization & Completeness ***

Date: _____ Time: _____ Verified By: _____
Member ID #: _____
List Document Used to Verify (attach a copy): _____
Physician Signature for Release of Psychiatric/Mental Health Records: _____
Printed Physician Name: _____Date: _____

Mail completed form to:
Hometown Health
10315 Professional Circle
Reno, Nevada 89521
Attention: Customer Service

□ Tracking only
□ Mail
□ Patient Pick-up at Professional Circle