

**AUTHORIZATION for VERBAL COMMUNICATION
WITH ANOTHER PERSON ON MY BEHALF**

I, _____
(print name of member), Member number: _____

authorize my health plan, Hometown Health (including Hometown Health Plan, Hometown Health Providers, and Senior Care Plus) to use and/or disclose my health and medical information, including but not limited to: referrals; claims; benefits; eligibility; appeals; premiums; and other healthcare provider records to:

Print Personal Representative(s) Name

Phone Number of Representative(s)

Relationship to Member

for the purpose of communicating with regard to my health insurance coverage.

I further understand that my health and medical information may include information about:

- Drug and/or alcohol abuse history, diagnosis and treatment;
- Psychiatric history, diagnosis and treatment; and
- AIDS/HIV, sexually transmitted diseases, hepatitis and or other infectious disease history, diagnosis and treatment.

I further understand that I must execute a separate authorization for the use and disclosure of any of my health and medical records and information that contain psychotherapy notes.

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that I may revoke or change this authorization in writing at any time, provided that I do so in writing or complete a new form with the changed information. I further understand that this authorization will stay in effective until I make a change (complete a new form) or revoke (in writing) this authorization.

Signature of Member

Date

Signature of Personal Representative(s)

Date

Print Representative(s) Authority and/or Power of Attorney

Signature of Representative(s) Authority and/or Power of Attorney

When you have finished filling out this form, please send it to:

Hometown Health
830 Harvard Way
Reno, Nevada 89502
Attention: Customer Services