

# 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  Other: \_\_\_\_\_  
or event maintained by Hometown Health

**I Specifically Authorize Release of These Records (these records will NOT be released unless you initial & check the box 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