

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