

Hometown Health Right of Access Form

Instructions: Please complete the following information exactly as it appears on your Member Identification Card (ID). Complete the form in its entirety and include as much information as possible. If necessary, call the Member Services Department Number found on your ID card for assistance. **This document is effective 12 months from date of signature.**

Note: This form does not need to be completed to share information with the legal guardian of an emancipated

Member Full Name:					
Member ID Number:		Primary Telephone Number:			
Date of Birth:		Secondary Telephone Number:			
Member Address:					
City:		State:		Zip Code:	

I authorize Hometown Health/Senior Care Plus, and its affiliates and agents, to disclose information about my health care and/or payment for my health care with the individual listed below:

Name:	Relationship:
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I do **NOT** authorize the release of the following types of sensitive information (check boxes that apply):

<input type="checkbox"/> Drug, Alcohol & Substance Abuse Records <input type="checkbox"/> Communicable Disease Records, including without limitation, HIV/AIDS Records <input type="checkbox"/> Genetic Testing Records	<input type="checkbox"/> Psychiatric & Mental Health/Behavioral Health Records <input type="checkbox"/> Other: _____ _____
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MEMBER SIGNATURE

DATE

Designated Legal Representative/Guardian

If this form is signed by a legal representative/guardian on behalf of an individual, please include the following: a copy of a Health Care Power of Attorney, a court order or other documentation establishing Custody or other legal documentation demonstrating the authority of the legal representative to act on the individual's behalf.

Legal Representative (print full name): _____

Representative's Relationship to member: _____

LEGAL REPRESENTATIVE SIGNATURE

DATE



Return completed form to:

Hometown Health Customer Service - Fax 775-982-3741
 10315 Professional Circle, Reno NV 89521
 CustomerService-HometownHealth@hometownhealth.com

