Nevada Authorization for the Use and Disclosure of Protected Health Information

Recipient's Name:_____

Nevada ID #: _____

I hereby authorize the use or disclosure of my protected health information by the _____ (person or organization) as described below. I understand the following:

- The information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.
- This authorization is voluntary and I may refuse to sign it. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or the ability to obtain treatment, except if the purpose of this authorization is for the person or organization to determine eligibility before enrollment; the person or organization reserves the right to deny enrollment or eligibility for benefits.
- I may inspect or copy the information used or disclosed.
- I may revoke this authorization at any time by notifying the person or organization in writing, except to the extent that action has already been taken as a result of this authorization.

Persons/organizations authorized to receive the information:
_____
_____
_____

Specific information that may be used/disclosed:
☐ Billing records
☐ My entire file
☐ Other: _____
Date range: _____

Information will be used/disclosed for the following purpose(s):
☐ Legal reasons
☐ Further medical care
☐ At my request

The person/organization authorized to use/ disclose the information will receive compensation for doing so:
☐ Yes
☐ No

This authorization expires on [upon] _____
[insert applicable date or event]

_____ _____
Signature of Recipient or Personal Representative | Date

_____ _____
Printed Name of Recipient or Personal Representative | Relationship to Recipient or Authority to Act on Their Behalf