



Authorization for Disclosure of Health Information

Please clearly print all names and other information.

Fax completed form to 775-352-7266

Patient/Member Name: _____

Patient/Member Social Security Number: _____ Date of Birth: _____

As described below, I hereby voluntarily authorize CDS Group Health to disclose my individually identifiable health information or that of _____

Covering records for the period from _____ to Current _____.

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist:

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> All hospital records (including nursing and progress notes) | <input type="checkbox"/> Medical records needed for the continuity of care |
| <input type="checkbox"/> Laboratory records | <input type="checkbox"/> Diagnostic imaging reports |
| <input type="checkbox"/> Transcribed hospital records | <input type="checkbox"/> Emergency and urgent care records |
| <input type="checkbox"/> Pathology reports | <input type="checkbox"/> Billing statement |
| <input type="checkbox"/> Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed). | |
| Describe: _____ | |
| <input type="checkbox"/> Other: <u>Benefits, eligibility, claims, case management services</u> | |

**Please note mental health information and/or records require a separate authorization.*

I understand the information will be disclosed only to the person(s)/organization(s) I list below for the purpose of administering insurance benefits, unless otherwise permitted by law.

Agent Name: _____

Company Contact Name: _____

Legal Representative Name: _____

Other (Name and relationship to the member): _____

I understand the information I have authorized CDS Group Health to disclose may include confidential, personal claims administration information and protected health information about me or my covered dependents.

I understand that I may revoke this authorization at any time by notifying CDS Group Health in writing. I also understand that upon the processing of this authorization by CDS Group Health, all previous authorizations signed by me are automatically revoked, but that a revocation will not have any effect on the actions taken by CDS Group Health before the revocation is processed.

I understand that the information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by law.

I understand that treatment or payment is not conditional upon this authorization.

This authorization expires two years from the date it is signed.

Signature of Patient/Member or Legal Representative

My facsimile signature is valid as if it were an original.

Date

Printed Name of Patient's Representative (if applicable): _____

Relationship to Patient: _____

****NOTE: Authorizations on behalf of another may only be completed by parents of minors or legal guardians.**