Authorization for Disclosure of Health Information

Please clearly print all names and other information.
Fax completed form to 775-770-9363

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:

- ☐ All hospital records (including nursing and progress notes)
- ☐ Laboratory records
- ☐ Transcribed hospital records
- ☐ Pathology reports
- ☐ Medical records needed for the continuity of care
- ☐ Diagnostic imaging reports
- ☐ Emergency and urgent care records
- ☐ Billing statement
- ☐ 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: _____
- ☐ Other: Benefits, eligibility, claims, case management services

**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 — Date

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

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.***