Southwest Medical
Home Health

PO Box 15645, Las Vegas, NV 89114-5675 Fax: (702) 242-7956

Authorization for Release of Health Information

Individual's Full Name	Date of Birth	Member or Subscriber ID #

Individual's Street Address	City	State	Zip Code

I understand and agree that:

- this authorization is voluntary;
- my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying Southwest Medical Home Health in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Who May Receive and Disclose my Information:

I authorize Southwest Medical Home Health and its affiliates to disclose my individually identifiable health information to the following person(s) or organization(s):

_____
(Full Name of Person(s) or Organization(s))

_____
(Full Address of Person(s) or Organization(s))

Type of Information to be Disclosed:

☐ I authorize disclosure of all my health information, including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; **or**

☐ I authorize only the disclosure of the following information:

_____
(Type of Information)

Purpose of Disclosure:

☐ My health information is being disclosed at my request or at the request of my personal representative; **or**

☐ My health information is being disclosed for the following purpose:

_____
(Explain Purpose)

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_____ _____
Signature of Individual Date

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

_____ _____
Signature of Individual's Representative Date

Personal Representative's:

_____ _____
Name Phone Number

_____ _____ __ _____
Street Address City State Zip Code

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

Please allow 7 – 10 business days from date of receipt by HIM Department for processing.
Phone: (702) 383-0887