Authorization for Disclosure of Protected Health Information (PHI)

General Authorization Form

Prominence Health Plan

Please clearly print all names and other information:

Member Name: _____
First Name Middle Name Last Name

Member Address: _____
Street City, State Zip Code

Member ID (from member ID card) # _____

If completing on behalf of a dependent under 18 years of age:

Dependents Name: _____
First Name Middle Name Last Name

Dependent Member ID# _____

I authorize Prominence Health Plan to disclose my Protected Health Information (PHI), or that of the listed dependent, as designated in the box below, to the following person or organization:

1. Name of individual or entity: _____

Relationship to individual/dependent: _____

Designee Address: _____
Street City, State Zip Code

Designee Contact Information: _____
Phone Number Fax Number

2. Name of individual or entity: _____

Relationship to individual/dependent: _____

Designee Address: _____
Street City, State Zip Code

Designee Contact Information: _____
Phone Number Fax Number

The person receiving the information must be 18 years of age or older.

_____ Explanation of Benefits (EOB)

_____ Enrollment Form

_____ Appeal Information

_____ Referral/Authorization

_____ Certificate of Creditable Coverage

_____ Premium Payment Results

_____ Claims

_____ Case Management Notes

_____ Other: _____

Complete medical records, including but not limited to drug, alcohol, & substance abuse, communicable diseases, genetic testing, and psychiatric, mental, and behavioral health records, will NOT be released. Please work with your treating physician to obtain your personal medical history.

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This authorization shall remain in effect from the dates signed below until (check only one):

☐ Date of my disenrollment from the health plan ☐ One year from the date this authorization is signed

☐ Specific expiration date (MM/DD/YYYY): _____

☐ Once the following event occurs: _____

***Please note, if this section is not completed, this authorization for disclosure will expire one year from the date it is signed.**

I authorize Prominence Health Plan and its subsidiaries/affiliates ("Health Plan") to use or disclose my medical, claim, or benefit records.I understand these records may contain information created by other persons or entities, including physicians and other health care providers.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my enrollment in the health plan, eligibility to receive benefits, ability to obtain treatment, or ability to receive payment for treatment unless allowed by law.

I understand that I may revoke this authorization at any time by notifying Health Plan in writing at the address below, except to the extent that:

a. Health Plan has taken action in reliance on this authorization; or
b. If the authorization was obtained as a condition for obtaining insurance coverage, another law provides the insurer with the right to contest a claim under the policy.

Health Plan will not receive compensation from a third party for using or disclosing this information.

I understand that once Health Plan has disclosed health information about me to a third party, the health information may no longer be protected by federal or state privacy laws. I agree that my facsimile or electronic signature can be treated as if it were my original signature.

_____

Printed Name of Member Date of Birth

_____

Signature of Member Date Signed

Please fax the signed form to Prominence Health Plan at (775) 770-9100 or mail it to:

Prominence Health Plan
Attn: Customer Service
1510 Meadow Wood Lane
Reno, NV 89502

If you have any questions, please contact us at (775) 770-9300 or toll-free at (866) 747-8855