Prominence®
Health Plan

Authorization for Disclosure of Protected Health Information (PHI)

Does not include mental health information

Please clearly print all names and other information:

Member Name: _____
First Name Middle Initial Last Name

Member ID (from Member ID card)#: _____

Member Date of Birth (MM/DD/YYYY): _____

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

Dependent's Name: _____

Dependent Member ID# _____
First Name Middle Initial Last Name

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

Name of individual or entity: _____

Relationship to individual/dependent: _____

_____
Address City State Zip code Phone FAX

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

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 records and progress notes)
_____ Pathology reports
_____ Medical records needed for the continuity of care
_____ Laboratory reports
_____ Transcribed hospital records
_____ Billing statements
_____ Emergency and urgent care reports
_____ Diagnostic imaging records
_____ Health screening results
_____ 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: _____

This authorization shall remain in effect from the date 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/YY): _____

❑ Once the following event occurs: _____

*Please note mental health information and/or records require a separate authorization. I understand the information will be disclosed only for the purpose of administering insurance benefits, unless otherwise permitted by law.

1510 Meadow Wood Lane, Reno, Nevada 89502
prominencehealthplan.com

I authorize Prominence Health Plan, and its subsidiaries/affiliates ("Health Plan"), to use or disclose my medical, claim, or benefit records, including any individually identifiable mental health information contained in these records, as described above. 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 authorization was obtained as a condition for obtaining insurance coverage, other 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 information about me has been disclosed by Health Plan to a third party, the health information may no longer be protected by federal or state privacy laws. I agree that my facsimile signature can be treated as if it were my original signature.

_____

Printed name of individual or individual's representative

_____

If representative, relationship to individual and authority to act for individual

_____

Signature of Patient, Member or Legal Representative

_____

Date

Please fax the signed form to Prominence Health Plan at 775.770.9034 or mail to:
Prominence Health Plan
Attn: Customer Service
1510 Meadow Wood Lane
Reno, NV 89502

If you have any questions, please contact the PHP Privacy Officer at 775.770.9444.