



Clark County, Nevada

Authorization to Use & Disclose Protected Health Information

This document authorizes Clark County to use and disclose Protected Health Information, as described below. Uses and disclosures of PHI will be consistent with Nevada and Federal law concerning the privacy of Protected Health Information. **Failure to provide all information requested will delay action on this Authorization.**

Specify the Clark County Department to process this request: _____

Client Name: _____
(please print)

Client Address: _____

Social Security Number: _____ Date of Birth: _____

Client ID#: _____

Specify method of receipt: Mail Call when ready for pickup, telephone# _____

Specify the Persons/Organizations who you are authorizing to receive your information:

Purpose of Requested Use or Disclosure:

Specify the information that may be Used or Disclosed:

The following items must be initialed to be included in the use and/or disclosure:

- | | |
|--------------------------|--|
| <input type="checkbox"/> | HIV/AIDS Related Information and/or Records |
| <input type="checkbox"/> | Mental Health Information and/or Records |
| <input type="checkbox"/> | Genetic Testing Information and/or Records |
| <input type="checkbox"/> | Drug/Alcohol Diagnosis, Treatment or Referral Information. |

Describe: _____

(Federal regulations require a description of how much and what kind of information is to be disclosed.)

This authorization expires (enter date or event): _____

PLEASE CONTINUE TO PAGE 2 TO COMPLETE THIS FORM



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NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this Authorization. I understand that my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.
- I understand that the person or entity that receives the information may not be covered by the federal privacy regulations; in that case, the information described above may be redisclosed and no longer protected by these regulations. I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for the use and/or disclosure.
- I may cancel this authorization at any time. Cancellation of my authorization must be in writing, signed by me (or on my behalf), and delivered to UMC/CLARK COUNTY Privacy Officer, 1800 W. Charleston Blvd., Las Vegas NV 89102. Cancellation of my authorization will be effective when Clark County receives my signed request, but it will not apply to the information that was used or disclosed prior to that date.
- I have a right to receive a copy of this authorization. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Print Client Name

Today's Date

Signature of Client or Client's Legal Representative

Print Name of Legal Representative (if applicable)

Relationship to Client (if not the Client)



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Instructions for Using the Authorization Form

Explanation of terms:

Use of Client information includes creating computer and paper records of Client registration data, services provided, supplies used, etc. Anything done to treat the Client, to secure payment, or while conducting daily operations is a use of PHI.

Disclosure occurs whenever protected health information is shared or used for any purposes outside of treatment/payment/operations.

Who may receive a request from a client:

Any Clark County hybrid-entity employee may receive a request for information to be disclosed or assist a Client in completing this form.

This document authorizes the Clark County) to use and disclose Protected Health Information, as described below. Uses and disclosures of PHI will be consistent with Nevada and Federal law concerning the privacy of Protected Health Information. Failure to provide all information requested will delay action on this Authorization.

HIPAA is very specific about the parts of an authorization that must be signed by the Client (or legal representative). Ensure the form is complete before taking any action or there will be a delay in providing or obtaining required Client information that may affect the Client. Refer to Clark County HIPAA Privacy Policies 1.3.C Defective Authorizations. Authorizations that are not valid may not be processed. Notify the requestor of the need to submit a valid authorization. While the use of Clark County's authorization form is not required, a copy may be sent to the requestor to facilitate obtaining a valid authorization.

Specify the Clark County Department to process this request: Identify your department, i.e. CCSS, DFS, EAP, JJS, Risk Management, etc. Provide enough information to determine location of requested information

Client Name: Print Client Name as registered. It must be legible. (please print)

Client Address:

Social Security Number: Date of Birth:

Client ID#: Enter your department ID # for the client, i.e. Case Number, PIN

Specify method of receipt: [] Mail [] Call when ready for pickup, telephone#

Specify the Persons/Organizations who you are authorizing to receive your information:



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- *Print the name and address of the person or company who is to receive the information.*
- *If a Clark County hybrid entity department is making the request, this box must specify the name or department / unit wanting the information.*
- *If the Client is the person requesting his/her own records, write "Client". Clients must complete this form even when requesting a copy of their own record. We must keep documentation for all requests.*

Purpose of Requested Use or Disclosure:

- *Explain why the information is needed. Examples may include: continuing care; a new doctor's appointment; insurance requirement; third party payer; Attorney – personal injury claim.*
- *If the Client is making the request for copies, he/she may enter "personal". Clients are not required to disclose why they are requesting copies. However, we are required to tell them what we are going to do with their information.*

Specify the information that may be Used or Disclosed:

- *This must be specific and descriptive. The Privacy rule does not allow non-specific terms such as "Client Records", "All Records", or similar phrases. Most descriptions should refer to specific portions of the record and/or specific dates of service.*
- *Specific reports or parts of the record must be listed. For example "Physical exam", "Billing records", or other common terms may be entered.*

The following items must be initialed to be included in the use and/or disclosure:

- HIV/AIDS Related Information and/or Records
- Mental Health Information and/or Records
- Genetic Testing Information and/or Records
- Drug/Alcohol Diagnosis, Treatment or Referral Information.

To release any of the record sets listed to the left, the Client must initial the individual boxes.

(Federal regulations require a description of how much and what kind of information is to be disclosed.)
Describe: Describe the actual drug/alcohol information that will be disclosed. Be specific.

This authorization expires (enter date or event): _____



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- *The Privacy Rule requires an expiration date or event. This field **must** be completed.*
- *The Client is allowed to specify an event such as “upon payment of claim” or “upon settlement”.*
- *The Client is allowed to specify a number of months or years the authorization is valid. There is no minimum or maximum expiration limit.*
- *For most uses, the period should not extend more than 1 year to protect the Client.*

NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this Authorization. I understand that my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.
- I understand that the person or entity that receives the information may not be covered by the federal privacy regulations; in that case, the information described above may be redisclosed and no longer protected by these regulations. I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for the use and/or disclosure.
- I may cancel this authorization at any time. Cancellation of my authorization must be in writing, signed by me (or on my behalf), and delivered to UMC/Clark County Privacy Officer, 1800 W. Charleston Blvd., Las Vegas NV 89102. Cancellation of my authorization will be effective when Clark County receives my signed request, but it will not apply to the information that was used or disclosed prior to that date.
- I have a right to receive a copy of this authorization. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Client's Name – Printed Legibly
 Print Client Name

Today's Date (mm/dd/yyyy)
 Today's Date

Client's or Legal Representative's Signature
 Signature of Client or Client's Legal Representative

Representative's Name – Printed Legibly
 Print Name of Legal Representative (if applicable)

*Examples include: Mother, Father,
 Spouse, Guardian, Adult Child*
Relationship to Client (if not the Client)