SIERRA HEALTH-CARE OPTIONS, INC.℠

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This is not a Durable Power of Attorney for Health Care Decisions

This authorization is voluntary. The information you authorize us to disclose may be subject to re-disclosure by the recipient and if the person or organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by the Federal privacy regulations.

You have the right to revoke any written authorization, except to the extent that we have taken action in reliance on the authorization, by writing to us at Sierra Healthcare Options, Inc., Attn. Prior Authorization Department, P. O. Box 15645, Las Vegas, NV 89114-5645. We may not condition your receipt of treatment, payment, enrollment, or eligibility for benefits on completion of this authorization.

ALL FIELDS MUST BE COMPLETED. See instructions on reverse.

1. **Member Name** (one member per form): ______________________
   (Please print)

2. **Member Number:** ______________________ **Date of Birth:** ______________

3. **I authorize Sierra Healthcare Options, Inc., ("SHO"), on behalf of itself and affiliated companies, to disclose my Protected Health Information designated in #4 below to the following person or organization**:

   Name of individual or entity: ______________________

   ____
   Address City State Zip code

   ______________ ______________
   Phone Fax

4. **I authorize SHO, on behalf of itself and affiliated companies, to disclose:**

   ☐ Information regarding eligibility, benefits, claim adjudication, prior authorization status and primary care physician assignment **AND/OR**

   ☐ The following specific information*: ______________________

   ____

   ____

   ***Information pertaining to substance abuse diagnosis or treatment requires completion of the Consent for Release of Confidential Health Information under 42 C.F.R. Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records.**

5. **Purpose of the disclosure**: I understand that the information designated in #4 above is being disclosed at my request.

6. **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: ______________________

7. **Member's Signature**: ______________________ **Date**: ______________

   Personal Representative's signature: ______________________ Date: ______________
   (if member is a minor and no sensitive health information is being disclosed or if the member is legally incapacitated)

   ______________________ ______________________
   Print name Relationship to member

   Legal Authority: ______________________

   Documentation of the personal representative's legal authority <u>must be attached</u>.