Prominence℠ Health Plan

Formerly Saint Mary's Health Plans

Authorization for Disclosure of Protected Health Information (ADPHI)

Does not include mental health information

Please clearly print all names and other information:

Policy Holder's Name: ______________________________

First Name *Middle Initial* *Last Name*

Policy Holder's Member ID#: ______________________ Policy Holder's Date of Birth (MM/DD/YYYY): ______________

As described below, I hereby voluntarily authorize Prominence Health Plan to disclose my individually identifiable health information or that of (dependent):

Associated Benefit Consultants - Carlton Combs, Mike Ashbaugh, Kelli Combs

First Name *Middle Initial* *Last Name*

(Complete only for minors)

If dependent: Dependent's Name: ______________________ Dependent Member ID# ______________

First Name *Middle Initial* *Last Name*

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:

N/A All hospital records (including nursing records and progress notes)

N/A Medical records needed for the continuity of care

N/A Emergency and urgent care reports

N/A Diagnostic imaging records

N/A 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: N/A

N/A Pathology reports

N/A Laboratory reports

N/A Transcribed hospital records

N/A Billing statements

N/A Health screening results

X Other: All Claims & Prior Auth information. Authorization to file Appeals.

* 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.

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 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 as well as information regarding the use of drug and alcohol treatment services or HIV/AIDS treatment. A separate form is required for the disclosure of mental health protected information.

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 on the back of the member's identification card, 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.

This authorization to use and/or disclose health information will continue for the duration of membership for the individual listed above.

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 775.770.9365 or mail to:

Prominence Health Plan
Attn: Member Services
1510 Meadow Wood Lane
Reno, NV 89502

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