



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:

- 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.

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.

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Print Client Name

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Today's Date

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Signature of Client or Client's Legal Representative

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Print Name of Legal Representative (if applicable)

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Relationship to Client (if not the Client)