HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

MRN#: _____

TOBACCO CESSATION PROGRAM RELEASE OF INFORMATION

First Name: _____ Last Name _____ DOB _____

Address: _____ City: _____ State: _____ Zip Code: _____

Authorize: _____TCP HEW_____
Tobacco Cessation Program Name of Provider

_____
Address City State Zip Code

Disclose to: Tobacco Cessation Program Records (including Educational and Financial Records)

Name of Facility, Provider or Person Phone Number

_____
Address City State Zip Code

The purpose of this release is:

- ☐ To assist with evaluation and education
- ☐ On-going verbal communication for continuity of care
- ☐ Referral to Behavioral Healthcare Options (BHO)
- ☐ Other (Specify) _____RX_____

The information to be released is:

- ☐ Medical History
- ☐ Diagnosis
- ☐ Prognosis
- ☐ Medical Questionnaire/Plan
- ☐ Social History
- ☐ Substance Use History
- ☐ Other (Specify) _____RX_____

Do Not Release Information Concerning: _____

I understand that my records are protected under State Confidentiality Statutes and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

This release expires:

- ☐ Upon Receipt of Information
- ☐ Date _____
- ☐ 30 days from termination of treatment

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

Patient's Signature: _____ **Date:** _____

Signature: _____
(IF GUARDIAN OR PERSONAL REPRESENTATIVE ATTACH SUPPORTING DOCUMENTATION)

Witness Signature: _____