Public Employees' Benefits Program
3427 Goni Road, Suite 109
Carson City, NV 89706
https://pebp.nv.gov
Email: memberservices@peb.nv.gov
Phone: 775-684-7000, 702-486-3100

Release of Information Authorization Form

I,_____, authorize the use and/or disclosure of my protected health information as set forth below.

1. The only protected health information that may be used or disclosed is as follows:

   _____

   (For example: "Any," "medical," "enrollment," etc., or a specific date range or provider name.)

2. The name, or other specific identification, of the person(s) or class of persons authorized to make use or disclosure of my protected health information:

   PUBLIC EMPLOYEES' BENEFITS PROGRAM
   3427 GONI RD, STE 109, CARSON CITY, NV 89706

3. The name, or other specific identification, of the person(s) or class of persons who are authorized to receive my protected health information:

Name	
Relationship	
Address	
Phone	

   (Besides a name, classes of people could be "nursing home staff" or "attorney" for example).

4. My protected health information will be used and disclosed for the following purposes only:

   _____

   ("At the request of the individual" is acceptable if participant does not want to state a purpose.)

5. This authorization will expire on _____(Must provide either a date or an event.)

6. I may revoke this authorization in writing at any time by contacting the party named above (#2 above) except to the extent that action has already been taken in reliance on this authorization. (This means that the authorization can be revoked, but anything done while this authorization was valid cannot be revoked.)

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient of the information and may no longer be protected by federal or state law. (Meaning party in #2 above is no longer liable once information is released upon proper authorization.)

8. I hereby certify that I have read the provisions in this authorization and understand and agree to its terms. I understand that if I request, PEBP will provide me a duplicate copy of this signed authorization.

Signature of participant or participant's personal representative	**Date**
Printed name of participant or participant's personal representative	**Participants SSN or PEBP ID #**
Relationship to participant/authority to act for participant *(NOTE: An authorized health care representative must attach documentation of the representative's authority to act on behalf of the participant.)*	