

Aging and Disability Services Division
Office for Consumer Health Assistance

Release of Information

_____ Consumer/Patient Name	_____ Date of Birth
_____ Parent/Guardian Name	_____ Relationship

I give permission for my health information to be shared.

I allow my health plan, doctor, hospital, or any other health care provider to share my health information with Nevada Aging and Disability Services Division (ADSD), and the Office for Consumer Health Assistance (OCHA).

I also allow OCHA to share this information with my health plan, doctor, hospital, or any other health care provider needed to help with my request for assistance.

I understand that:

- I can ask for a copy of the privacy rules.
- I do not have to sign this form.
- I can cancel this permission at any time. I must turn in my request in writing to OCHA if I want to cancel my permission.
- OCHA will not share any health information after I end the permission. Information may have been shared before it was cancelled.
- A copy of this form can be accepted, it does not have to be original.
- If I think I have been treated unfairly because my HIV/AIDS-related information was shared, I can contact the Office of Civil Rights.
- ADSD shares information to make decisions about my services.
- When ADSD shares information based on this release to a recipient, the information may be shared by the recipient and no longer be protected by federal or state law.
- I will not hold ADSD employees responsible for sharing information to those listed on this form.
- My permission will end when my case is closed, or I cancel it.

Aging and Disability Services Division
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Release of Information

Consumer/Parent/Guardian Signature

Date

ADSD Employee Signature

Date

OCHA Case Number

You can reach out to OCHA if you need assistance or have any questions or concerns.

Office for Consumer Health Assistance
7150 Pollock Drive
Las Vegas, NV 89119
Phone: (702) 486-3587 or (888) 333-1597
Fax: (702) 486-3586