AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Social Security No: _____

I hereby authorize the use or disclosure of the above named individual's health information as described below:

1. The following individual or organization is authorized to make the disclosure:

   _____

2. The type and amount of information to be used or disclosed is as follows:
   BILLING INFORMATION AND ANY OUTSTANDING BALANCES ON ACCOUNT
3. This information may be disclosed and used by the Clients' Security Fund, or their authorized representatives (www.nvbar.org/csf), c/o State Bar of Nevada, 3100 W. Charleston Blvd., Ste. 100, Las Vegas, Nevada 89102, for the purpose of investigation and potential client reimbursement.
4. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. Unless otherwise revoked, this authorization will expire one year from the date this authorization is signed, or at the end of the litigation, which ever is last to occur.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I have read the above and authorize the disclosure of the protected health information as stated. A photocopy of this Authorization shall have the same force and effect as the original.

_____ _____

Signature of Patient or Legal Representative Date

Subscribed and sworn before me this _____ day of _____, 20__.

_____

NOTARY PUBLIC