

Nevada CARA Plan of Care Recipient Consent for Release of Information

Client Information

Client Name: _____ Date of Birth: _____ Phone: _____

Client Address: _____ City _____ State _____ Zip _____

Client Email Address: _____

Insurance Plan Information

_____ Private Insurance _____ Medicaid

Managed Care Organization _____

Member Number _____ Group Number _____

Use and Disclosure of CARA Plan Of Care

I hereby authorize _____ to release the CARA Plan of Care developed on my behalf to

(Healthcare Facility)

_____. I understand that this release will facilitate the coordination of my care by

(Managed Care Organization)

allowing the insurance provider to contact me with information regarding services that I am eligible for under my

insurance plan. I consent to allow the Managed Care Organization to re-disclose the information to a service provider in

order to connect me to services that are within the specialized program offered to me.

I understand that I may revoke my consent to release information at any time. This consent form is valid for one year from the date the release is signed or as otherwise stated.

(Client Signature)

/_____
(Date)

Sign below ONLY if you wish to revoke your consent.

Revocation of consent: I hereby revoke the above consent for release of information.

Upon revocations of consent, further release of specified information shall cease immediately.

(Client Signature)

(Date)