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)