Kansas Authorization For Release Of Protected Health Information

In regards to:

Client name: _____

Client ID or SSN: _____

Please fill in ALL blanks

I, _____ hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization (*or class of persons*) authorized to provide the information:
   _____
   _____
2. Specific person/organization (*or class of persons*) authorized to receive and use the information:
   _____
   _____
3. Specific and meaningful description of the information:
   Please describe the information you wish DHCF and DCF to disclose, for example:

   ☐ Written, electronic and oral information related to eligibility for benefits for the time period commencing on _____ date and continuing through _____date.

   ☐ Written, electronic, and oral information including claims, reports, and other documents related to claims for benefits for an injury or illness commencing on _____date and continuing through _____date.

   ☐ Written, electronic and oral information relating to payment or lack of payment of benefits to _____ for services rendered on _____date.

   ☐ Other: _____
   _____
4. Purpose of the request:
   Please state the purpose of the request below. (For example, to discuss my benefits with the Benefits Administration staff so that I can better understand my benefits.) If you do not wish to state a purpose, please state, “At the request of the individual.”
   _____

   _____

5. Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the person/organization listed in number 1 above in writing at _____. I understand that any use or discloser made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.

7. I understand that I am entitled to receive a copy of this authorization.

8. I understand that this authorization will expire on _____ (insert an expiration date. If no date is inserted, the authorization will expire 12 months from the date entered in 9).

9. DHCF will not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.

_____ _____

Signature of Individual Date

If a Personal Representative executes this form, that Representative warrants that he/she has authority to sign the form on the basis of:

_____

_____

_____

This authorization reflects the requirements of 45 CFR § 164.508 (August 14, 2002).