

**KHPA – State Employee Health Plan
Authorization Form For Release of Medical Information**

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

1. Specific person/organization authorized to provide the information – (mark all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Blue Cross Blue Shield of Kansas | <input type="checkbox"/> Caremark Prescription Drug Plan |
| <input type="checkbox"/> Coventry Health Care of Kansas | <input type="checkbox"/> Delta Dental of Kansas |
| <input type="checkbox"/> Preferred Plus of Kansas | <input type="checkbox"/> SilverScript Part D Prescription Drug Plan |
| <input type="checkbox"/> Physician or Hospital. Please specify: _____ | |
| <input type="checkbox"/> Other Please specify: _____ | |

2. Specific person/organization (or class of persons) authorized to receive and use the information:

- State Employee Health Plan, 900 SW Jackson, Rm. 900-N, Topeka, Ks. 785.296.6280
- Other (Please specify): _____

3. Specific description of the information to be used or disclosed. (Include dates as appropriate):

4. Purpose of the request: (Check one)

- At the request of the individual.
- At my request to review my medical claims and explain the information to me.
- Other: _____

5. Right to Revoke: I understand that this authorization is voluntary and that I have the right to revoke this authorization at any time by notifying the State Employee Health Plan (in writing) at 900 SW Jackson, Rm 900-N, Topeka, KS 66612. I understand that such a revocation is only effective after it is received and logged by the Plan Administrator. I understand that any use or disclosure made prior to the revocation of 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 and the information described on this form if I ask for it.

8. I understand that this authorization will expire:

One year from the date of this authorization.

On the following date: _____, 20__.

9. The Plan will not condition treatment, payment, enrollment or eligibility for benefits on receipt of an authorization.

Signature of Individual

Date

Signature of Personal Representative

Date

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

a signed Personal Representative Form;

Other _____

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

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