KANSAS STATE EMPLOYEES HEALTH PLAN

Authorization Form

Authorization 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 (*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 the Plan to disclose, for example:

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

   ☐ *Written and electronic 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 and electronic information relating to payment or lack of payment of benefits to [name of health care provider] for services rendered on _______________________ [date.*]

   ☐ Other:

   ____

   ____

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4. Purpose of the request:

   Please state the purpose of the request below. [for example*, to discuss my benefits with the Fund and its TPA 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 [*list address to which revocation must be delivered*]. I understand that the revocation is only effective after it is received and logged by the person/organization listed in number 1 above. I understand that any use or disclosure 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 or event, for example, one year*].

   ____

   ____

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

______________________________ ______________________________
Signature of Individual Date

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