Upon completion, please send this form to:
DHCF Privacy Officer
KDHE Legal Services
1000 SW Jackson, Ste 560
Topeka, KS 66612

In regards to:

Client name: ______________________

Client ID or SSN: __________________

Authorization for Release of Protected Health Information
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).