Authorization to Use and Disclose Protected Health Information Form

Under the HIPAA Privacy Rule, an individual may authorize the release of his or her protected health information (PHI) to a specific person or entity. Please follow the instructions below for completing this Kentucky Health Cooperative Inc. (KYHC) standard Authorization to Use and Disclose Protected Health Information Form. If you need assistance in completing this authorization form, please call us at 1855-OURKYHC.

Please remember:

- One authorization form can be used for a range of and/or multiple services or providers.
- Authorization forms can be completed claim by claim, procedure by procedure, or for services within specified timeframes.
- The individual's use of the authorization form is always voluntary.

I. Individual (Name and information of person whose protected health information is being disclosed):

____

Name Date of Birth

____

Member ID Group # Social Security Number

____

Address City State ZIP

(   )________________________ Area Code & Telephone Number

All of the information in Section I pertains to the individual for whom the authorization is being requested. The individual may be the subscriber, his or her spouse, a dependent or any other individual covered or applying for coverage under the subscriber's membership.

II. Authorization and Purpose:

I request and authorize KYHC to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected.

____

Persons/Organizations authorized to receive your information Purpose

____

Address City State ZIP

Section II identifies the person/entity that will be receiving the PHI about the individual identified in Section I. An individual could authorize disclosure of his or her PHI to a close friend, a broker, an attorney, or a specific member of his or her employer's benefits staff. The individual may also authorize disclosure to an organization.

III. Specific Description of Information to be Used or Disclosed ***NOTE*: *This Authorization CANNOT be used to disclose Psychotherapy Notes.***

A. Release of Sensitive Protected Health Information

You must check "yes" or "no" if you authorize the release of medical information, test results, records or communications specific to:

____ Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome

____ Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases);

____ Drug, alcohol or substance abuse;

____ Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions); and ____ Genetic testing.

B. Release of Protected Health Information *(check one or more)* **Dates of Services**

		From:	**To:**
Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).	______	______
Claims:	Includes information related to payment of claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.).	______	______
Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.	_______	______
Premium:	Includes information related to billing cycles, Bank account information, etc.	_______	______
Services from (*provider or supplier*):	Provider name (Includes information related to services rendered by a specific provider or supplier):_______________________________	_______	______
Other:	(Specify other information that is not listed in one of the categories above.)	_______	______

IV. Expiration and Revocation:

Expiration: This authorization will expire on (must choose one):

_____One year from the date it is signed _____Other (*insert date or event*):____________

Right to Revoke:

I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative)**:**

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

____

Signature Date: *(month/day/year)*

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of these documents if they are already on file with KYHC.

____ Personal Representative's Name Relationship to Individual

____

Personal Representative's Address City State ZIP

____ Personal Representative's Area Code & Telephone Number

BEFORE RETURNING THIS FORM--KEEP A COPY FOR YOUR RECORDS

If you need assistance completing the form, please refer to the instructions above or contact the Customer Service number listed on the back of your Member Identification Card.

Mail the completed signed authorization to:

Kentucky Health Cooperative Inc.
Attn: Privacy Office
9700 Ormsby Station Rd. Suite 100
Louisville, KY. 40223