

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

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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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