Employee Name: ______________________________________
Employee Id Number: ________________ **Date:** __________

Authorization for Release of Your Protected Health Information

I. Your Protected Health Information

The Kentucky Employee Assistance Program (KEAP) is a confidential program designed to help employees and their families deal with problems that may affect job performance, their personal life, and their general well-being. KEAP assists employees and their dependents with getting help for any number of personal problems including substance abuse, depression, anxiety, marital problems, financial problems, and problems with parenting. Each person seeking assistance through KEAP receives a confidential assessment with a trained professional. The assessment may be conducted face-to-face or by telephone. Once a thorough assessment is conducted, the KEAP associate may make a referral to the most appropriate professional or resource and provide assistance in making contact with those resources.

Through the assessment/referral process, KEAP may collect and maintain protected health information ("PHI") that includes personal identifiers, insurance information, and health information. Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), KEAP may use and disclose your PHI for treatment, payment, or health care operations including, but not limited to, patient referrals, claims processing, preauthorization, and case management. Other uses and disclosures permitted or required by HIPAA are outlined in KEAP's Notice of Privacy Practices.

II. Your Rights

Except as otherwise described in KEAP's Notice of Privacy Practices, KEAP may not use or disclose PHI without a valid authorization. In particular, a valid authorization is required:

- For any use or disclosure of **Psychotherapy Notes**, except to carry out certain treatment, payment, or health care operations or to defend KEAP in a legal action or other proceeding brought by you;
- For any use or disclosure of PHI for **Marketing**, except if the communication is in the form of a face-to-face communication made by KEAP to you, or a promotional gift of nominal value is provided. "Marketing" does not include communications made to describe a health-related product or service that is provided by, or included in the plan of benefits, of KEAP;
- For any disclosure of PHI which is a **Sale** of such information.

You may, at any time, revoke an authorization previously given provided the revocation is in writing. The revocation will not apply to the extent that KEAP has taken action in reliance on the authorization.

III. Authorization to Release Your PHI

For a valid authorization, complete the following:

(a) Identify and describe, in a specific and meaningful fashion, the information authorized to be used or disclosed.

____

____

(b) Provide the name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure (i.e. KEAP).

____

____

Employee Name: ____
Employee Id Number: ________________ Date: __________

(c) Provide the name or other specific identification of the person(s), or class of persons, to whom KEAP may make the requested use or disclosure.

____
____

(d) Provide a description of each purpose of the requested use or disclosure.

____
____

(e) Provide an expiration date or an expiration event.

____

(f) *For KEAP purposes only:* If this authorization is to allow KEAP to use and disclose PHI for marketing purposes, KEAP [☐ will] [☐ will not] [☐ not applicable] receive financial remuneration from a third party.

IV. Signature of Member or Member's Personal Representative *(Form MUST be completed before signing.)*
By signing below, you understand:

- You may revoke this authorization at any time provided the revocation is in writing. The revocation will not apply to the extent that KEAP has taken action in reliance on the authorization. A written revocation, specifying the authorization intended to be revoked, shall be submitted to the Privacy Officer at the address below.
- You are not required to sign this authorization as a condition to treatment, payment, enrollment, or eligibility for benefits under KEAP. This authorization is voluntary and you may refuse to sign it.
- Information disclosed pursuant to this authorization is subject to possible re-disclosure by the recipient and will no longer be protected.

____
Printed Name of Member

____
Signature of Member or
Member's Personal Representative

Date:______________________________

____
Printed Name of Member's Personal Representative
(If Applicable)

____
If a Personal Representative – Describe Relationship to Member. Include authority/documentation proving status as a Personal Representative.

Remit Form To:

Sharron S. Burton, Privacy Officer
Office of Legal Services
Personnel Cabinet
501 High Street, 3rd Floor
Frankfort, KY 40601
Fax: (502) 564-7603
Sharron.Burton@ky.gov

V. KEAP Response to Your Authorization

____
Signature of KEAP Privacy Officer

Date Received:______________________________

Date Copy Mailed to Member: ________________________