Member Name: ___________________________________
Planholder SSN:_________________ Date: __________
Member Relationship to Planholder ________________

AUTHORIZATION FOR RELEASE OF YOUR PROTECTED HEALTH INFORMATION

I. Your Protected Health Information

The Kentucky Employees' Health Plan ("KEHP") collects and maintains protected health information ("PHI") that includes personal identifiers, enrollment, eligibility, and dependent and qualifying event information. KEHP utilizes a third-party claims administrator and a pharmacy benefits manager, referred to as "Business Associates," to carry out certain functions for KEHP. Because of their administrative responsibilities, these Business Associates create, receive, maintain, and transmit PHI on behalf of KEHP. Like KEHP, the Business Associates are responsible for ensuring the protection of your health information.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), KEHP and its Business Associates may use and disclose your PHI for treatment, payment, or health care operations including, but not limited to, claims processing, billing, case management, provider credentialing, and utilization review. Other uses and disclosures permitted or required by HIPAA are outlined in KEHP's Notice of Privacy Practices.

II. Your Rights

Except as otherwise described in KEHP's Notice of Privacy Practices, KEHP 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 KEHP 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 KEHP 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 KEHP;
- 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 KEHP has taken action in reliance on the authorization.

Member Name: ___________________________________
Planholder SSN:__________________ Date: ___________
Member Relationship to Planholder _________________

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.

KEHP and KEHP personnel
____
____

(c) Provide the name or other specific identification of the person(s), or class of persons, **to whom** KEHP 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 KEHP purposes only:* If this authorization is to allow KEHP to use and disclose PHI for marketing purposes, KEHP [☐ 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 KEHP 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.

Member Name: __________________________________
Planholder SSN:_________________ Date: __________
Member Relationship to Planholder ________________

- You are not required to sign this authorization as a condition to treatment, payment, enrollment, or eligibility for benefits under KEHP. 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	Printed Name of Member's Personal Representative (If Applicable)
____________________________________	____
Signature of Member or Member's Personal Representative	If a Personal Representative – Describe Relationship to Member. Include authority/documentation proving status as a Personal Representative.

Date:________________________________

Remit Form To: William H. Adams II, Privacy Officer
Personnel Cabinet
501 High Street, 4th Floor
Frankfort, KY 40601
Fax: (502) 564-7603
Will.Adams@ky.gov

V. KEHP Response to Your Authorization

____
Signature of KEHP Privacy Officer

Date Received:______________________________________

Date Copy Mailed to Member: ________________________