KENTUCKY HEALTH ADMINISTRATORS
1721 Fortune Court, Ste #150
Lexington, KY 40509
office 866.664.3261 fax 630.206.1055
kyhealthadmin.com

PRIVACY *Authorization* FORM

Authorization to Use or Disclose Protected Health Information (PHI)

REGARDING

GROUP NAME: _____

MEMBER RELEASING PHI: _____

MEMBER DATE OF BIRTH: _____

I hereby authorize **KENTUCKY HEALTH ADMINISTRATORS** to use and/or disclose the protected health information described below to the individual identified as:

RELEASING PHI TO (MEMBER NAME): _____

RELATIONSHIP: _____

Effective as of _____, this authorization for release of information covers the period of healthcare for all past, present, and future claims. I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

This medical information may be used by the individual I authorize to receive this information for medical treatment, consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization by written, dated communication at any time. I understand it is my responsibility to update the authorization on file with Kentucky Health Administrators when there is a family status change. I understand that a revocation of this authorization will not be effective regarding any information obtained by the individual acting in reliance of this authorization prior to the date of the revocation.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the individual and therefore may no longer be protected by federal or state law.

SIGNATURE OF MEMBER _____

PRINTED NAME OF MEMBER _____

DATE _____

Please submit this authorization form to:

Kentucky Health Administrators
Attn: PHI Authorizations
P.O. Box 54290
Lexington, KY 40555-4290
FAX (630) 206 – 1055 | EMAIL elig@kyhealthadmin.com