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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION AND PROTECTED FINANCIAL INFORMATION

The purpose of this release is to authorize disclosure of Protected Health Information and Protected Financial Information to the individual(s) named on this form. This designation will not affect benefits, claims processing and payment, or eligibility status.

Type of Information

The Kansas Health Insurance Association (KHIA) may discuss or release Protected Health Information (PHI) and Protected Financial Information (PFI) to authorized individual(s) regarding the following information: eligibility, billing, payment status, benefits, claims, medical information used to make payment decisions, providers, appeals, and complaints about my employer sponsored coverage(s).

Authorized Use and/or Disclosure

I authorize KHIA to release PHI and PFI to my Designated Authorized Individual(s) for the purpose of assisting with, or facilitating, the coordination or payment of my plan benefits. I also understand that if an authorized individual is not a health care provider, or other person subject to federal privacy laws, my PHI and PFI may no longer be protected by those privacy laws and may be subject to re-disclosure by the authorized person(s). KHIA is not responsible should the authorized individual(s) further disclose my protected PHI and PFI information. I further understand that I have the right to limit the information that is released under this authorization. Limitations for disclosure are identified below. By leaving this section blank, I am creating no limitation on disclosure of PHI or PFI.

Disclosure Limitations: _____

Expiration and Revocation

The authorization to release information to authorized individual(s) will automatically expire 365 days following the termination of my plan enrollment. I understand that I may revoke this authorization at any time by giving written notice to KHIA. Revocation will not affect any action that KHIA has taken, or any information that has already been released based upon prior authorizations.

Designation of Authorized Individual(s)

Name of Authorized Person	Phone Number ()	*Privacy Password
Name of Authorized Person	Phone Number ()	*Privacy Password

**Privacy Password – such as mother’s maiden name, your elementary school, birth city, etc.*

Signature and Authorization

I, the undersigned, do hereby swear that I am the above-mentioned member or an authorized legal representative of the above-mentioned member. I have read and understand the content of this Authorization to Release Information Form. My signed authorization is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

X _____ / /
 Signature of Member/Legal Representative Date

Printed Name of Legal Representative

Description of Legal Representative’s
 Relationship to Member