HIPAA / PROTECTED HEALTH INFORMATION RELEASE FORM

Patient Details

Patient Name (first, middle, last name): Date of Birth:

Address (Street Address, City, State, Zip Code): Group ID #:

SS #:

Phone #: Email:

Guardian or Legal Representative (*if the patient is under 18 years of age*)

Name of Guardian or Legal Representative (first, middle, last name):

Address & Phone:

Release of PHI

I hereby authorize the use or disclosure of protected health information about me by The Kempton Group Administrators, Inc. / The Kempton Company and any Business Associate of The Kempton Group Administrators, Inc. / The Kempton Company.

The following person (or class of persons) may **receive** disclosure of protected health information about me:

The specific information that should be disclosed (Specifically and meaningfully describe the protected health information that this authorization will allow to be used and/or disclosed):

I authorize the disclosure of:

Mental Health information: ☐ Y ☐ N Psychotherapy Notes: ☐ Y ☐ N Alcohol/Substance Abuse Information ☐ Y ☐ N

Please read the following - No Conditions: This authorization is voluntary. The Plan will not condition your enrollment in a health plan or eligibility for benefits on receiving this authorization. Effect of granting this Authorization: The protected health information described may be disclosed to and/or received by persons or organizations who are not subject to federal health information privacy laws. These persons or organizations may further disclose protected health information, and it may no longer be protected by federal health information privacy laws.

Person/Organization to Release Information

Person/Organization to Release Information: The Kempton Group Administrators, Inc. / The Kempton Company, *Administrator of Advantage Health Plans Trust*

Address (Street Address, City, State, Zip Code): 13431 Broadway Ext., Suite 130, Oklahoma City, OK 73114 (800) 324-9396

Expiration and/or Revocation

This authorization MUST have an expiration **date** or **event** listed per federal law.

☐ This authorization will expire on

OR

☐ This authorization will expire on or after the occurrence of the following event (*which must relate to the individual or to the purpose of the use and/or disclosure being authorized*):

Right to Revoke:

You may revoke this authorization at any time by giving written notice of revocation to the contact listed below. Revocation of this authorization will not affect any action taken by the Plan prior to our receipt of your written revocation.

The Kempton Group Administrators, Inc. / The Kempton Company, *Administrator of Advantage Health Plans Trust*
13431 Broadway Extension, Suite 130, Oklahoma City, OK 73114 Ph: (800) 324-9396 / Email: customerservice@kemptongroup.com

Signature

I, the undersigned, have had full opportunity to read and consider the contents of this authorization. I understand, that by signing this form, I am confirming any authorization for the use and/or disclosure of my protected health information, as described in this form.

Patient Printed Name | Patient or Representative Signature | Date

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name | Relationship to Individual

When requesting medical information for clinical review, we will respect privacy guidelines and confidentiality as defined in the HIPAA regulations. YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT. Include this authorization in the individual's records. Send a copy to the Privacy Official.

Please return this form to The Kempton Group Administrators, Inc. / The Kempton Company, *Administrator of Advantage Health Plans Trust*
Email: customerservice@kemptongroup.com / Fax: (405) 608-5098
Mailing Address: 13431 Broadway Extension, Suite 130, Oklahoma City, OK 73114

HIPAA / PHI Release Form Instructions

The instructions below will assist you in completing the HIPAA / PHI Release Form.
Note: This form must be filled out and signed by the ***patient*** unless the patient is under 18 years of age.

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1) Patient Details

a) In this section, please provide the requested details.
b) Full legal name, date of birth, address, social security number, and phone number ***must be included***.

2) Guardian or Legal Representative

a) If the patient is under 18 years of age, please list the Guardian or Legal Representative information in this section, otherwise, ***leave blank***.

3) Release of PHI Instructions

a) This section of the form outlines who is releasing the PHI and who is receiving the PHI. **This section must be filled out and cannot be left blank.**

i) Checkboxes
   (1) ***Common*****:** Please check the *first box* if you want The Kempton Company (Administrator of Advantage Health Plans) to be able to talk to someone else (for *example, your spouse, parent, medical advocate*).
   (2) ***Rare***: Please check the *second box* you are using this form to give someone else permission to talk to us.

ii) Question 1 - please write the name of the person/company who is supposed to *receive* your information.
   (1) ***Common*****:** If you want us to be able to talk **to** someone, please list their name here (*example: your spouse, parent, medical advocate*).
   (2) ***Rare:*** If you want someone else to talk to us, please list The Kempton Company.

iii) Question 2 - you are ***required by law*** to list exactly what type of protected health information (PHI) you want to be shared.
   (a) For example, a patient may choose to write something similar to *all medical information*, *only information regarding my knee surgery*, *etc*.

iv) Question 3 -you are ***required by law*** to indicate whether Mental Health Information should be released. You must choose Y or N *even if this question does not apply*, an answer is required.

v) Question 4 - you are ***required by law*** to indicate whether covered psychotherapy should be released. You must choose Y or N *even if this question does not apply*, an answer is required.

vi) Question 5 - you are ***required by law*** to indicate whether Alcohol or Substance Abuse information and/or psychotherapy notes should be released. You must choose Y or N *even if this question does not apply*, an answer is required.

4) Person/Organization to Release Information

a) Please fill out the details of whom you want to be able to release your information.
    i) This information is pre-filled for your convenience.

5) Expiration and/or Revocation

a) You MUST include either an expiration date or event listed per federal law.
    i) You may list any date in the future when you wish the authorization to expire.
    ii) You may list an event
        (1) For example, a patient may choose to write something similar to: "*when I am no longer enrolled in the health plan*."
b) If you wish to revoke the authorization on a specific date or during a certain time frame, please write that here.

6) Signature

a) Sign and date the form unless younger than 18 years of age.
b) If the patient is younger than 18 years of age, the guardian or legal representative must fill out Personal Representative Name and Relationship to Patient.

Questions?

If you have any questions or concerns, please call the Kempton Care Advocate team at (800) 324-9396. They would love to assist you with any additional information you need.