AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I,_____, Social Security Number:_____-_____- _____ DOB ___ /___ /___
Name of client **[optional]**

hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that signing this form is voluntary.

Providing the information:
Person(s)/Organization(s) (check all that applies)
_____Community Mental Health Center(s)
name _____
_____Intermediate Care Facility/Nursing Facility/Hospital
name _____
_____State Agency/Department
name _____
_____Community Developmental Disability Organization(s)
name _____
_____Aging and Disability Resource Center
Other(s): Name/Address/Phone_____
_____

Receiving the information:
Person(s)/Organization(s) (check all that applies)
_____Aging and Disability Resource Center
name _____
_____Kansas Department for Aging and Disability Services

Other(s): Name/Address/Phone _____
_____
_____
_____
_____

Description of Information to be Used or Disclosed includes, but is not limited to:
Any and all documents that provide contact information for client, client's legal representative, and guardian; documentation created by a licensed medical provider evaluating the client's cognitive status within the last calendar year to date; documentation detailing the client's behavior status within the last calendar year to date, current or most recent Level of Care score established through a Kansas-approved assessment tool, documentation detailing the client's nutrition status within the last calendar year to date, health status, documentation related to client's home environment, client's income and asset(s) information, services listed on client's Person-Centered Service Plan, name and contact information of people living in my home or other individuals who provide informal supports to me.
Use or disclosure not listed above (other): _____

The purpose of the Use or Disclosure:
The information released or obtained will be used for eligibility determination for Home and Community Based Services (HCBS), Senior Care Act (SCA) or Older Americans Act (OAA). Forms completed using the information may include the functional assessment for each of the above listed programs which follow the State and Federal regulations governing the functional eligibility requirements for HCBS Waiver Services, SCA and OAA. The functional eligibility assessments are part of the eligibility process to receive in-home services through a Managed Care Organization (MCO) or local Area Agency on Aging (AAA). The organization requesting this Release will not receive any financial or in-kind compensation in exchange for using or disclosing the health information described above.

The Individual or the Individual's Representative must read or have the following read to them and initial by each item below:

_____ *(Initials)* I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that the refusal to sign this authorization may mean that the use and/or disclosure described in this form will not be allowed.

_____ *(Initials)* I understand this Release is valid for one year from today's date.

_____ *(Initials)* I understand that I may revoke this Release at any time by notifying the **providing organization** in writing. It will not have an effect on actions that were taken prior to the revocation.

_____ *(Initials)* I understand that once the uses and disclosures have been made pursuant to this authorization, the information released may be subject to re-disclosure by any recipient and will no longer be protected by federal privacy laws.

_____ *(Initials)* This will not condition treatment or payment on my providing authorization for this use or disclosure except to the extent the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I certify that I agree to the uses and disclosures listed above and that I have received a copy of this Authorization. (Form must be completed before signing.)

_____ _____
Signature Date

_____ _____ _____
Signature of Personal Representative (if applicable) Date Description of Authority