HIPAA AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please Print Clearly and Complete in its Entirety

I hereby authorize the University of Kentucky Benefits Office to disclose Personal Health Information about me relating to my coverage under the (Please select all that apply):

□ HEALTH PLAN □ DENTAL PLAN □ VISION

Please return this form to: University of Kentucky 1080 Export St Ste. 280, Lexington, KY 40504
Phone: 1-859-257-9555 Opt. 3 Fax: 1-859-323-1095 E-mail: benefits@email.uky.edu

Disclosure is initiated by me and authorized for the following purpose/reason (Please select one):

- □ To assist me in my inquiry about claims or other activities related to my health, dental and/or vision benefits.
- □ I elect not to provide a statement of purpose/reason. Please make the disclosure at my request.
- □ Other purpose/reason – describe in detail.

_____
_____
_____

Personal Health Information to be disclosed (Please select one):

- □ I authorize University of Kentucky to release my personal health information relating to my health, dental, and/or vision benefits (including billing, claims, and plan information) for (check one) □ all years, or □ the current year, or □ the following years: _____.

OR:

- □ The personal health information described below (Please provide a detailed description including dates if applicable. The University of Kentucky will not make a disclosure unless the information requested to be disclosed is specifically identified).

_____
_____
_____

Covered Person Name - First, Middle, Last (Print)	**Employee SSN or ID#**
Address:	

Name and address of person or entity authorized to receive the specified Personal Health Information:

_____

_____

_____

By signing below, I acknowledge and understand that:

• This authorization is voluntary.

• This authorization will expire on _____. If no date is provided, the Authorization will expire upon termination of enrollment in the applicable benefits plan.

• I may revoke this authorization at any time by writing to The University of Kentucky Benefits Office at the address above. If I do not revoke this authorization, it will be valid until such time as I am no longer covered under this health, dental, and/or vision benefit plan. My revocation will not apply to any action taken before The University of Kentucky Benefits Office receives it.

• The plan(s) may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

• Personal Health Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by applicable privacy laws.

• The University of Kentucky Benefits Office, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of my Personal Health Information as authorized on this form.

• I have received a copy of this completed and signed form.

Signature of Covered Person or Personal Representative of the Covered Person:

_____ Date:_____

If signed by Personal Representative of the Covered Person, please describe the authority under which the Personal Representative is authorized to act:

_____

_____