

HIPAA / PROTECTED HEALTH INFORMATION RELEASE FORM

Patient Details

Patient Name (first, middle, last name): Date of Birth:
Address (Street Address, City, State, Zip Code): Plan 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. or the Plan Administrator, as described below:

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.**
Address (Street Address, City, State, Zip Code): **13431 Broadway Extension, Suite 130, Oklahoma City, OK 73114** Telephone: **(800) 521-1711**

Expiration and/or Revocation

This authorization can **ONLY** remain in effect for **12 months** following the executed date per federal law.

If you wish for this authorization to terminate on a specific date, or after a specific event, please indicate below:

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. 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.
Email: customerservice@kemptongroup.com
Fax: (405) 521-9804
Mailing Address: 13431 Broadway Extension, Suite 130, Oklahoma City, OK 73114