KEPRO
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Member Name: _____ **DOB:**____/____/____ **SSN:**____-____-____

I,_____, hereby authorize
(name and address)

_____
(name and address of organization and/or person making disclosure)

to disclose to_____and
(name and address of organization and/or person receiving information)

authorize _____
(name and address of organization and/or person disclosing or re-disclosing information)

to disclose to _____
(name and address of organization and/or person receiving disclosed or re-disclosed information)

The following information:

____Medical history, examination reports, and medications
____Operation reports
____X-ray reports
____HIV test results
____Fitness for duty concerns
____Alcohol, drug abuse reports
____Other:_____
____Laboratory reports
____Prescriptions
____Consultations
____Diagnosis
____Results of drug screens
____Job performance functions
____Hospital records, reports, dates of hospitalization and discharge
____Reports of participation and progress and treatment
____Discharge plans
____Treatment or tests
____Copies of all other reports
____Mental health records, psychiatric, social, psychological, and other allied health evaluations

Purpose(s) or need(s) for release:
____Ongoing diagnosis, treatment planning, social, vocational, fiscal or educational planning
____Determining the appropriateness of services being provided and coordination of diagnostic evaluation, treatment planning and/or medical, social, vocational and/or psychological service delivery
____Rehabilitation case management of medical condition as a result of a workers' compensation injury
____Claims appeal or claims processing
____For any lawful purpose
____Other

This authorization includes the types of information set forth above generated until the date of signature AND subsequently if generated before: (Provide date):_____.

I understand that individually identified health information ("IIHI") is protected under Federal and/or State confidentiality law. I further acknowledge that the information to be released was fully explained to me and this authorization is given of my own free will. I may withdraw this authorization to disclose IIHI at any time by written revocation except to the extent that the program or person that is to make this disclosure has acted in reliance on it. Upon revocation of this authorization, further release of IIHI authorized by this shall cease immediately. If not previously revoked, this authorization will terminate upon year(s) from the date written on this form. A file copy is considered equivalent to the original.
I understand that if the organization authorized to receive the information is not a health plan or health care provider, or a contractor thereof, the released IIHI may no longer be protected by federal privacy regulations. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand that KEPRO will [not] receive financial or in-kind compensation in exchange for using or disclosing the IIHI described above.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent, Guardian or Authorized Representative, (if required, and relationship) Date

Witness: _____

Patient is: Minor Incompetent Deceased

Legal Authority: Parent or Legal Guardian Next of Kin of Deceased

The person signing this authorization is entitled to a copy.

TO THE RECIPIENT OF CONFIDENTIAL INFORMATION: PROHIBITION ON REDISCLOSURE. If the information disclosed to you relates to alcohol and other substance abuse treatment, this information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecue any alcohol or other substance abuse patient.