HIPAA / PROTECTED HEALTH INFORMATION RELEASE FORM

Patient Details

Patient Name (first, middle, last name):

Address (Street Address, City, State, Zip Code):

Telephone (with area code):

Date of Birth:

Plan ID #:

Social Security Number:

Email:

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

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

Address:

Telephone:

Email:

Release of PHI

I hereby authorize the use or disclosure of protected health information about me by Advantage Health Plans Trust, or The Kempton Company, as the Plan Administrator of Advantage Health Plans Trust, as described below:

1. The following person (or class of persons) may receive disclosure of protected health information about me:
2. 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):
3. I authorize the disclosure of Mental Health information: ☐ Y ☐ N
4. I authorize the disclosure of psychotherapy notes ONLY: ☐ Y ☐ N
5. I authorize the disclosure of any Alcohol or Substance Abuse information and/or psychotherapy notes ☐ 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 the 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: Advantage Health Plans Trust

Address (Street Address, City, State, Zip Code): 13431 Broadway Extension, Suite 130, Oklahoma City, OK 73114

Telephone (with area code): (800) 521-1711

Email: customerservice@kemptongroup.com

Expiration and/or Revocation

This authorization will remain in effect for 12 months following the executed date.

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 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 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 copy to the Privacy Official.