INDIVIDUAL AUTHORIZATION to REVIEW

The Plan: Kenai Peninsula Borough School District Group Health Plan

The Plan Sponsor: Kenai Peninsula Borough School District

Please complete the following form to specify the use or disclosure of health information that you are authorizing. Federal rules providing certain protections of the privacy of individuals' health information may require your authorization before the Plan may use, receive or disclose health information. If you are completing this form to allow use or disclosure of anyone's health information other than your own, including your child's health information, the pronouns "I" and "you" in the form below refer to that other individual. Authorizing the use or disclosure of another individual's health information requires certification and demonstration of authority to act on behalf of that individual to give that authorization. If the Plan requested this authorization, please note that the Plan's request should not be taken as an indication that the Plan has concluded that the use or disclosure for which the Plan is requesting your authorization would be prohibited if you do not give the requested authorization.

Name of individual whose health information is to be used or disclosed pursuant to the following Authorization:

Authorization to Use or Disclose Health Information

I hereby authorize the use or disclosure of my health information as described in this Authorization. I understand that this Authorization is voluntary and that I may revoke it at any time by giving a written statement that I am revoking this Authorization to the person or organization named in Item 2 as being authorized to use or disclose my health information.

KENAI PENINSULA BOROUGH SCHOOL DISTRICT GROUP HEALTH PLAN

Authorized Use or Disclosure

1. Specific description of the health information that I am authorizing to be used or disclosed (including dates to which the information pertains, if applicable): _____

   _____

2. Name, or other specific identification, of the person(s) or organization(s) I am authorizing to *use* or *disclose* the health information identified in Item 1: _____

   _____

3. Name, or other specific identification, of the person(s), or organization(s) I am authorizing to *receive* the health information identified in Item 1: _____

   _____

4. Check one of the following statements, as applicable:

   __ The use or disclosure of the health information described in Item 1, by and/or to the person(s) and/or organization(s) specified in Items 2 and 3 is at my request.

   __ The purpose(s) for which I am authorizing use or disclosure of the health information described in Item 1, by and/or to the person(s) and/or organization(s) specified in Items 2 and 3:

5. This authorization will expire on _____, 20__, or if it is not possible to specify a particular date, upon the occurrence of the following event: _____

   _____.

Print name_____Date_____

Signature _____

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KENAI PENINSULA BOROUGH SCHOOL DISTRICT GROUP HEALTH PLAN

Important Information about This Authorization and Your Rights

You may refuse to sign this Authorization. The Plan will not condition eligibility for, enrollment in, or payment of benefits under the Plan on provision of this Authorization.

You may revoke this Authorization at any time by giving your written, signed statement that you are revoking this Authorization to the person(s) or organization(s) specified in Item 2 (preceeding page). If the Plan is the organization specified in Item 2, you can submit your revocation to the following:

Kenai Peninsula Borough School District Health Plan
148 N. Binkley St
Soldotna AK 99669
Fax (907) 262-9645

Your revocation will be effective when received, but any use or disclosure occurring before receipt of your revocation will not be affected by it. In addition, if action has been taken in reliance on the Authorization, you will not be able to revoke the Authorization with respect to subsequent uses and disclosures in connection with that action.

You may inspect or copy the health information described in Item 1 by requesting to do so.

If health information is disclosed pursuant to this Authorization it may no longer be protected under the terms of the federal rules providing certain protections of the privacy of individuals' health information, and that health information may be re-disclosed by the recipient. You may wish to obtain assurances from the person(s) or organization(s) specified in Item 3 that they will not further disclose your health information that they receive pursuant to this Authorization.

If the Plan is requesting this Authorization, you will be provided with a signed copy of it.

Note:
If the Authorization is signed by someone other than the individual whose health information is to be used or disclosed pursuant to this Authorization, the person signing the foregoing Authorization must complete and sign a Personal Representative Authorization form describing what authority the signer has to act for such individual.

I hereby certify that I have read the provisions of this Authorization, and that I understand and agree to its terms.

Print name_____Date_____

Signature _____

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PERSONAL REPRESENTATIVE AUTHORIZATION

By signing below you certify and attest that you are the duly authorized personal representative of the individual whose health information is to be used or disclosed pursuant to the foregoing Authorization, and that you have the lawful authority to give the foregoing Authorization on behalf of such individual for the following reason (check the applicable reason):

☐ The individual whose health information is to be used or disclosed pursuant to the foregoing Authorization is an un-emancipated minor child, and

1. You are the parent, guardian, or other person legally acting in the place of a parent (a "Parent") of the un-emancipated minor child whose health information is to the foregoing Authorization (the "Child").

2. You have authority under applicable law to make decisions related to health care for the Child,

3. The health information specified in Item 1 of this Authorization is relevant to your acting as a Parent of the Child, and

4. None of the following situations apply:

    a. The Child has not requested that you be treated as the Child's Parent or other personal representative, and the health information specified in Item 1 relates to a health care service for which:

        (i) The Child consented; and

        (ii) No other consent was required by applicable law

    b. The health information specified in Item 1 relates to a health care service which the child can obtain without the consent of a Parent, and the Child, a court, or another personal authorized by law consented to such health care service.

    c. The health information specified in Item 1 relates to a health care service with respect to which a Parent of the Child has assented to an agreement of confidentiality between the health care provider providing the health care service and the Child with respect to that health care service.

☐ The individual whose health information is to be used or disclosed pursuant to the foregoing Authorization is an adult or an emancipated minor, you have authority under applicable law to act on behalf of that individual in making decisions related to health care for that individual, and the health information specified in Item 1 of this Authorization is relevant to your personal representation of that individual.

☐ The individual whose health information is to be used or disclosed pursuant to the foregoing Authorization is deceased, you are the executor, administrator or other individual authorized under applicable law to act on behalf of that individual or that individual's estate, and the health information specified in Item 1 of this Authorization is relevant to your personal representation of that individual or that individual's estate.

Print name_____Date_____

Signature _____