Carondelet Health & Affiliates Employee Health Care Fund

Authorization for the Use and Disclosure of Protected Health Information

I hereby authorize the use or disclosure of my protected health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Description of information that may be used/disclosed:

   ❒ Medical Information ❒ Dental Information

   ❒ Healthcare Reimbursement Account Info.

   Specific description of information to be used/disclosed: _____

   _____

2. The information will be used or disclosed for the following purpose(s):

   _____

   _____

3. Persons/organizations authorized to use or disclose the information:

   ❒ Carondelet Health ❒ Delta Dental of Missouri

   ❒ Coventry Healthcare of Kansas ❒ Kansas City Life Insurance (Healthcare Reimbursement Acct)

4. Persons/organizations authorized to receive the information:

   _____

   _____

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under number 6 on this form.

6. If the purpose of this authorization is for Carondelet Health & Affiliates Employee Health Care Fund to determine eligibility before enrollment, the requested use or disclosure is not for psychotherapy notes, and I refuse to sign this authorization, Carondelet Health & Affiliates Employee Health Care Fund reserves the right to deny enrollment or eligibility for benefits.

7. I understand that I may inspect or copy the information used or disclosed.

8. I understand that I may revoke this authorization at any time by notifying Carondelet Health & Affiliates Employee Health Care Fund in writing, except to the extent that:

   (a) action has been taken in reliance on this authorization; or

   (b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

   To revoke the authorization, I must notify Carondelet Health at the following address:

   Donna Sumner
   Carondelet Health
   1000 Carondelet Drive
   Kansas City, MO 64141

10. I understand that I have a right to request and receive a Notice of Privacy Practices from Carondelet Health & Affiliates Employee Health Care Fund.

11. **This authorization will expire 90 days from the date of my signature or on the following date or event (please specify): _____**

_____ _____
Signature of Member or Member's representative | Date

_____ _____
Printed name of Member or Member's representative | Relationship to Member, or representative's authority to act for the Member, if applicable