

4. Purpose of the request:

Please state the purpose of the request below. [For example, to discuss my benefits with the Benefits Administration staff so that I can better understand my benefits.] If you do not wish to state a purpose, please state, "At the request of the individual."

5. Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the person/organization listed in number 1 above in writing at [list address to which revocation must be delivered]. I understand that the revocation is only effective after it is received and logged by the person/organization listed in number 1 above. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.

7. I understand that I am entitled to receive a copy of this authorization.

8. I understand that this authorization will expire on (insert an expiration date. If no date is inserted, the authorization will expire 12 months from the date entered in 9).

9. KHPA will not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.

Signature of Individual

Date

If a Personal Representative executes this form, that Representative warrants that he/she has authority to sign the form on the basis of:

This authorization reflects the requirements of 45 CFR § 164.508 (August 14, 2002).