ES 3904
08-15

WHOSE Records to be Disclosed:

SSN	First	Middle	Last
NAME			
(KDHE Internal)	Date of Birth (mm/dd/yy)		

HIPAA COMPLIANT AUTHORIZATION TO DISCLOSE INFORMATION TO: Kansas Department of Health & Environment

****PLEASE READ THE ENTIRE FORM BEFORE SIGNING BELOW****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of **All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to: Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501). Drug abuse, alcoholism, or other substance abuse. Sickle cell anemia. HIV infection including AIDS or test for HIV or sexually transmitted diseases. Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and affects my ability to work.
3. Copies of educational tests and evaluations, including Individualized Education Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

All medical and psychological sources

All educational sources

Social worker/rehabilitation counselors.

Consulting examiners used by KDHE.

Employers and others who may know about my condition

THIS BOX TO BE COMPLETED BY KDHE (as needed). Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM : The State agency authorized to process my case and other contracted agencies directly involved in the determination (DCF and Disability Determination Services), and doctors or professionals consulted during the process.

PURPOSE; Determining my eligibility for medical assistance, including looking at the combined effect of any impairments that by themselves would not meet the definition of disability.

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature). I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above. I understand that there are some circumstances where this information may be redisclosed to other parties. I may write to revoke this authorization at any time. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization. I will be given a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed. **I have read this form and agree to the disclosures above from the types of sources listed.**

INDIVIDUAL authorizing disclosure: **IF not signed by subject of disclosure, specify basis for authority to sign**

Parent ☐ Guardian ☐ Other personal representative (explain) ☐

SIGN ➡

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

WITNESS (ONLY required if the claimant signed with an "X".) I know the person signing or am satisfied of this person's identity:

SIGN ➡

This general and special authorization to disclose was developed with the provisions regarding disclosure of medical, educational, and other information under: P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code Section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.4475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State Law.