## Authorization for Release of Information

Kent County Health Plan

I. Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information from the Plan as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the Plan.

Individual's name: _____

Persons/organizations authorized to receive the information:

_____

_____

_____

Specific description of information to be used or disclosed:

_____

_____

_____

Specific purpose of the disclosure:

_____

_____

_____

This authorization will expire _____ (indicate date, or an event relating to you personally or to the purpose of the authorization).

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

a. I may revoke this authorization at any time prior to its expiration date by notifying the Plan in writing, but the revocation will not have any affect on any actions the Plan took before it received the revocation.

b. I may see and copy the information described on this form if I ask for it.

c. I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

d. The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity.

III. Signature of Individual or Individual's Representative

_____ _____

Signature of Individual or Individual's Representative (Form MUST be completed before signing.) Date

Printed name of the Individual's personal representative: _____

Relationship to the individual, including authority for status as Representative: _____