

Bluegrass Family Health

Authorization for the Use and Disclosure of Individually Identifiable Health Information

I, _____, hereby authorize Bluegrass Family Health to use and/or disclose my protected
Name and Social Security Number of Insured

health information described below to _____
Name of person or organization that is to receive the information

This authorization applies to the information described below (mark all those that apply):

- Records covering the period of time for _____ to _____.
- Information regarding the following condition or injury [please describe] _____
on or about this date _____.
- Other [please be specific and include dates] _____.

The information will be used and/or disclosed for the following purpose (check one):

- At the request of the individual
- Other [please describe in specific detail] _____.

I understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or the ability to obtain treatment, **except that**,

- if this authorization is for BFH to determine eligibility before enrollment, and the requested use or disclosure is not for psychotherapy notes, then BFH reserves the right to deny enrollment or eligibility for benefits if I refuse to sign, **or**
- if this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, then BFH reserves the right to deny that health care if I refuse to sign.

I understand that I have a right to request and receive a copy of BFH's Notice of Privacy Practices.

I understand that I have the right to revoke this authorization at any time by sending written notification to Bluegrass Family Health, Attention Privacy Officer, 651 Perimeter Drive, Suite 300, Lexington, KY 40517.

I understand that a revocation is not effective to the extent that the persons I have authorized to use and/or disclose my individually identified health information have acted in reliance upon this authorization.

I further understand that if this authorization was obtained as a condition of obtaining insurance coverage, other law provides BFH with the right to contest a claim under the policy, or the policy itself.

I understand the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

This authorization will expire in **two (2) years**. If you wish for this authorization to expire **sooner**, please enter the date of expiration: [please list a **specific date**]: _____.

Please keep a copy of this authorization for your records.

Signature of Insured **or** Personal Representative (i.e., Legal Guardian, Power of Attorney)

Date

Print Name of Insured or Personal Representative

Member ID Number of Insured

Description of Personal Representative (Please provide representative documentation)