

Authorization for the Release of Information

I, _____, authorize _____
(Name of Customer and Customer ID #, if applicable) (Name of ADRC/AAA to disclose)
to release and/or share pertinent information in regards to my assessed level of care, services and/or case.

Name of agency/organization(s) and/or customers the information may be released to and/or obtained from:

- _____ Aging and Disability Resource Center/Area Agency on Aging
 - Kansas Department for Aging and Disability Services (KDADS) and its authorized business associates
 - Kansas Department for Children and Families (DCF), Human Service Specialist (HSS) Staff
- Managed Care Organization:
- Amerigroup Sunflower United
 - Other (Ex: Family, Doctor, Discharge Planner, etc.), as described below:

_____	_____
(Name of Party)	(Organization or affiliation to customer)
_____	_____
(Name of Party)	(Organization or affiliation to customer)
_____	_____
(Name of Party)	(Organization or affiliation to customer)

Information to be released and/or shared includes, but is not limited to:

Contact Information; Cognitive Status; Behavior Status; Level of Care Score; Nutrition Status; Health Status; Environment; Income and Asset Information; Services Listed on my Plan of Care; Name and Number of People Living in my Home

Other (must be listed): _____
Other (must be listed): _____

The purpose of Authorization for the Release of Information:

The information released or obtained will be used for eligibility determination for Medicaid—Home and Community Based Services (HCBS), Senior Care Act (SCA) Services, or Older Americans Act (OAA) Services. Forms completed using the information may include the Functional Assessment Instrument (FAI), Uniform Assessment Instrument (UAI), and/or Multi-Functional Eligibility Instrument (MFEI) which are in compliance with the State and Federal regulations governing the functional eligibility requirements for HCBS Waiver services, SCA, and OAA. The FAI and UAI are part of the functional eligibility process to receive in-home services through a Managed Care Organization, or a local Area Agency on Aging (AAA). The organization requesting this Release will not receive any financial or in-kind compensation in exchange for using or disclosing the health information described above.

The Individual or the Individual’s Representative must read and initial the following:

- I understand that I may inspect or copy the protected health information to be used or disclosed under this Authorization for Release. I understand that I have the right to (or will receive) a copy of this Authorization.
- I understand I may refuse to sign this Authorization for Release. I understand that I might be denied services if I refuse to sign this release for purposes of treatment, payment, or health care operations (enrollment or eligibility for benefits). I will not be denied services if I refuse to authorize release of information for other purposes. I understand that the refusal to sign this Authorization may mean that the use and/or disclosure described in this form will not be allowed.
- I understand this Authorization for Release is valid for one year from today’s date.
- I understand that I may revoke this Authorization for Release at any time by notifying the providing organization in writing. It will not have an effect on actions that were taken prior to the revocation.
- I understand that once the uses and disclosures have been made pursuant to this Authorization for Release, the information released may be subject to re-disclosure by any recipient and will no longer be protected by federal privacy laws.

To revoke this authorization, contact your Aging and Disability Resource Center/Area Agency on Aging at () _____, or the Kansas Department for Aging and Disability Services at 1-800-432-3535 to receive contact/address information.

(SIGNATURE OPTIONS ON BACK PAGE)

I have read (or someone has read to me) the above information. I have been given an opportunity to ask questions, and my questions have been answered to my satisfaction. I authorize the use and disclosure of my protected health information for the purpose of this Authorization for Release.

SIGNATURE OPTION 1: CUSTOMER CAPABLE OF SIGNING

Signature of Customer

Date

Printed Name of Customer

SIGNATURE OPTION 2: CUSTOMER HAS AUTHORIZED AGENT

Printed Name of Customer

Signature of Parent, Guardian or Legally Authorized Representative of Customer

Date

Printed name of Parent, Guardian or Legally Authorized Representative of Customer

Describe relationship to customer including the legal authority this individual has to act on behalf of the customer. (Check one below)

- Parent**
- Agent acting for customer under an activated Durable Power of Attorney**
- Legal guardian**
- Health care surrogate**
- Other; specify _____**

SIGNATURE OPTION 3: CUSTOMER PHYSICALLY UNABLE TO SIGN AND NO DPOA OR GUARDIAN

Signature of Witness

Date

Printed name of Witness

Describe why a witness signature is required and the relationship of the witness to the Customer.

