HIPAA AUTHORIZATION TO RELEASE INFORMATION

Member Name:	**Patient's Date of Birth:**
Address:	**Member ID #:**
Address:	

1. I, _____, authorize the release, use and disclosure of my health information as described below.

2. This information is to be disclosed to:

Kepro
6802 Paragon Place Suite 440
Richmond, VA 23230
PH#: 800-634-4832 FAX#: 512-975-7642

3. I understand that this authorization may or can include Behavioral Health, Alcohol and Substance Abuse, Genetic Testing, Sexually Transmitted Disease or HIV/AIDS information.
4. This information for which I am authorizing disclosure will be used to allow the above organization assure continuity of care with my health care providers, including carrying out discharge planning arrangements; to carry out utilization review and quality assurance activities; and to determine clinical eligibility for covered benefits; and to make payment decisions.
5. I hereby release Kepro and its employee from any and all liability that may arise from the release of information as I have directed.
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my Health Plan when the law provides my Health Plan with the right to contest a claim under my policy.
7. Unless I specify differently, this authorization will expire one year from the date signed below.
8. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
9. I reviewed the Consumer Bill of Rights and Disclosure regarding case management services. I fully understand that case management participation is voluntary. I consent to Kepro's case management program. This written consent is valid for one year.

_____ _____
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____