AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions: All of the blocks (1-6) ***must*** be completed.
If any block is ***not*** completed, then this "Authorization" form will be considered incomplete and cannot be used.

Please print all information legibly, except for the required signatures.

Block 1 – Identification of Patient/Participant

Participant Name: _____ Date of Birth _____

Block 2 – Type of Records/Information to be Disclosed and/or Re-disclosed:

- Status in KNAP including non adherence, withdrawal or dismissal;
- Lab results (urine, blood, saliva, hair, nails);
- Work performance;
- Assessment of my ability to practice nursing;
- Return to work accommodations; and
- The nature of my referral

Block 3 - Kansas Nurse Assistance Program and its representatives may disclose the above records to and may receive the above records from:

Employer: _____ Employer Phone #: _____

Employer Address: _____

Supervisor: _____ Supervisor Phone #: _____

Supervisor Email Address: _____

Hire Date: _____ Primary Employment? _____ Full-time, Part-time or PRN? _____ Require license? _____

Block 4 - Expirations: This "Authorization" will stay in effect indefinitely. Revocation of authorization must be delivered in writing.

Block 5 - Purpose for which you want records disclosed: To determine any status regarding any illness(es) that has or could affect my practice, to coordinate my care and to monitor my recovery.

Block 6 - Authorizing Signature (I authorize the disclosure of the records/information described above and:

- I understand that if the person, agency, or organization that receives the described records/information is not subject to the federal privacy regulations; the records/information may be re-disclosed and no longer protected by those regulations.
- I also understand that certain records may be protected by federal or state law, including alcohol/drug treatment, psychiatric treatment, mental health treatment or communicable disease and unless a restriction is noted in Block 2 above, I am requesting that any and all such protected records be released under this authorization.
- I understand that I may revoke this authorization at any time by delivering a written revocation to **Kansas Nurses Assistance Program, 6405 Metcalf, Suite 502, Overland Park, KS 66202 (913) 236.7575.**
- If I revoke this authorization, it will have *no* effect on actions already taken on reliance of this form.
- I understand that I may refuse to sign this form and that my treatment or payment for my treatment will not be affected if I do not sign this form unless my treatment includes research, or the reason for my treatment is to disclose information to another.
- I have read and understood this form. I am the patient/participant listed above in section (1). I also permit disclosure of the records based upon a photocopy of this authorization.

_____ _____

Signature of Participant Date of Signature

IMPORTANT NOTE: This information ha s been disclosed to you form records protected by Federal confidentiality rules (42 CFR P art 2) or other laws and /or internal policy. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical information or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For referrals not known to the Kansas State Board of Nursing; this release is signed authorizing our office to share information from your file to KSBN in the event you become non-compliant with our program.