PROTECTED HEALTH INFORMATION ACCESS REQUEST FROM INDIVIDUAL

This form needs to be completed and signed, where appropriate, for the Kenton County Airport Board ("Board") to process the request. If you want to receive information for more than one Individual, please submit a separate, completed form for each Individual.

1. Individual Information

(Information About Person Whose Records are Being Requested).

Last Name	First Name	Middle Initial

I.D. Number (If Applicable)	Social Security Number	Birth Date (MM/DD/YYYY)

Street Address	City, State and Zip Code

Daytime Telephone Number (include area code)

2. Description of PHI Records being Requested

Please indicate in the lines below the specific records that you are requesting. In doing so, be sure to include the names of any specific documents, a detailed description of any information being sought, and/or the incident or medical event related to such records.

☐ Airport Police Department (APD) Report; number (if known): _____
☐ Emergency Medical Services (EMS) Report; number (if known): _____
☐ Aircraft Rescue Fire Fighting (ARFF) Report; number (if known): _____
☐ Closed Circuit Television (CCTV) footage*
☐ Description of other specific records:

_____
_____
_____

*Please submit an additional request in accordance with Kentucky Revised Statutes section 61.870 et seq. and further detailed in the Kenton County Airport Board Rules and Regulations section 01.065.

3. Time Period for Requested Records

Upon receipt of this signed PHI Access Request Form, the Board will provide you with the requested PHI within their possession for the last 12 months. If instead of the most recent 12 months of data, you need PHI to include date from a different period, please indicate the data range below:

From: _____ To:_____

Important Notice to Individual(s) signing this PHI Access Request Form:

- **The PHI provided in response to this request may include diagnosis and treatment information, such as information on chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually-transmitted diseases, HIV/AIDS, and/or genetic marker information.**

Signature of Individual, Individual's Legal Representative, or the Individual's Natural or Adoptive Parent	Date
Printed Name of the Individual, Individual's Legal Representative, or the Individual's Natural or Adoptive Parent	

If this request is signed by the Individual's Legal Representative, you must furnish a copy of the health care power of attorney or other relevant document legally authorizing the Legal Representative to act on behalf of the Individual, as applicable.

4. Authorization (If applicable).

If the PHI requested is to be sent to someone other than the Individual, the Individual's Legal Representative, or the Individual's Parent, if the Individual is an unemancipated minor child, the recipient must complete Section 4 and the corresponding Authorization.

AUTHORIZATION

I hereby authorize the Board and any of its parents, subsidiaries, or other affiliates, and their respective employees, agents, and subcontractors, to disclose protected health information about the Individual, specified in Section 1 of this form to the authorized recipient designated herein. This authorization applies only to fulfilling this request for access to PHI. The scope of access indicated herein shall govern all of the Recipient's access. Treatment, payment and

eligibility for benefits do not depend on whether I sign this form. Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy regulations. This authorization may be revoked by providing written notice to the Board at the address indicated below at any time, or through submitting Form 003 to the Board.

Printed Name of Recipient
Recipient's Mailing Address Street Address: _____ City, State: _____ Zip Code: _____

Date of Expiration of Authorization: _____ (Should Individual fail to indicate an expiration date, such authorization will terminate after sixty (60) days from its execution).

Signature of Individual, Individual's Legal Representative, or the Individual's Natural or Adoptive Parent	Date
Printed Name of the Individual, Individual's Legal Representative, or the Individual's Natural or Adoptive Parent	

If this request is signed by the Individual's Legal Representative, you must furnish a copy of the health care power of attorney or other relevant document legally authorizing the Legal Representative to act on behalf of the Individual, as applicable.

Return this completed form to:

Kenton County Airport Board
Scott Gibbons
Vice President Business Administration
P.O. Box 752000
Cincinnati, Ohio 45275-2000
Facsimile: 859-767-7813

Please allow 30 days for our response.