HIPAA AUTHORIZATION FOR BOARD ACCESS

This Authorization form is to be used solely for granting the Board, and its designated representatives, the right to access your PHI from other Covered Entities directly. Such authorization is not required for the Board to use and disclose PHI with Business Associates or as is required by law, more specifically discussed in the HIPAA Policy.

I, ______________________________, direct any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf or anyone who rendered payment to such aforementioned entities OR those parties specifically identified as____ to disclose and release my protected health information described below to my employer:

Kenton County Airport Board
c/o:____________________________
P.O. Box 752000
Cincinnati, Ohio 45275

Health Information to be disclosed upon the request of the person named above-
(check either A or B):

☐ A. **Disclose** my complete health records (including but not limited to diagnosis, lab tests, prognosis, treatment, and billing, for all conditions) **OR**

☐ B. **Disclose** my health records, as above, **BUT do not disclose** the following (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): ______________________________________

This authorization for release of information covers the period of healthcare from:

☐ __________ to __________
☐ All past, present, and future periods

Form of Disclosure (unless another format is mutually agreed upon between my provider and employer):

☐ An electronic record or access through an online portal
☐ Hard copy

This authorization shall be effective until the date or event specified below, unless I revoke it before such date or time (Check one):

- ☐ Date: ___________________
- ☐ Event: ___________________

Scope of Authorization or Access: Such disclosure shall be made for the purpose of (Please check "at the request of the individual" or provide a description for each purpose of this disclosure):

- ☐ At the request of the individual
- ☐ Other purposes as described here:

____
____
____
____

I understand that I have the right to revoke this authorization, in writing, at any time or through the execution of HIPAA Form 003. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditions on whether I sign this authorization.

____   _________________________

Name of the Individual Giving this Authorization   Date of Authorization

____

Date of Birth

Return this completed form to:

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