Authorization to Use and Disclose Health Information

8325 Lenexa Dr. Ste 410
Lenexa, KS 66214

Notice to Member:

- Completing this form will allow Sunflower Health Plan to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to give permission to use or share your health information. Your services and benefits with Sunflower Health Plan will not change if you do not submit this form.
- If you want to cancel this authorization form, send us a written request to revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling Customer Service at the phone number on the back of your member ID card.
- Sunflower Health Plan cannot promise that the person or group you allow us to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.
- If you need help, contact Customer Service at the phone number on the back of your member ID card.
- Fill in all the information on this form. When finished, mail the form and any supporting documentation to:

  Sunflower Health Plan
  ATTN: Compliance Department
  8325 Lenexa Dr., Ste. 410, Lenexa, KS 66214

Aviso al (la) afiliado(a):

- Al llenar este formulario, usted autoriza a Sunflower Health Plan a (i) que use su información de salud para un fin en particular, y/o (ii) que la dé a conocer a la persona o entidad que usted identifique en este formulario.
- Usted no tiene que firmar este formulario ni dar permiso a usar o dar a conocer su información de salud. Sus servicios y beneficios de Sunflower Health Plan no cambiarán si usted no firma este formulario.
- Si desea cancelar este formulario de autorización, envíenos por escrito una solicitud para revocarlo a la dirección que aparece al final de esta página. Servicios para los afiliados puede proporcionarle un formulario de revocación si les llama al número telefónico que se encuentra en la parte trasera de su tarjeta de identificación de afiliación.
- Sunflower Health Plan no puede prometer que la persona o el grupo al que nos permita dar a conocer su información de salud no la dará a conocer a alguien más.
- Conserve una copia de todos los formularios llenos que nos envíe. Si las necesita, podemos enviarle copias.
- Si necesita ayuda, comuníquese con Servicios para los afiliados al número telefónico que aparece en la parte trasera de su tarjeta de identificación de afiliación.
- Llene toda la información en este formulario. Al terminar, envíe el formulario y todos los documentos de apoyo a

  Sunflower Health Plan
  ATTN: Compliance Department
  8325 Lenexa Dr., Ste. 410, Lenexa, KS 66214

KDHE-Approved 8/8/2024

Please read the instructions carefully and complete ALL FIELDS below. Incomplete forms cannot be accepted.

1 Member Information:

Member Name *(print)*: _____

Member Date of Birth: _____ Member ID Number: _____

2 I give Sunflower Health Plan permission to share my health information with the person/group named below. The purpose of the authorization is *(check one option)*:

□ Coordinate Care or Benefits: To allow Sunflower Health Plan to communicate with the named person/group **OR**

□ Records Request: To request Sunflower Health Plan to send my health information to the named person/group *(dates or description of records to be sent)*: _____

_____

3 Person or Group to Receive Information *(add more Persons or Groups on next page)*:

Name (person or group): _____

Address: _____

City: _____ State:_____ Zip: _____ Phone: _____

4 I authorize Sunflower Health Plan to use or share all of my health information [Genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records (please specify any substance use disorder information that may be disclosed: _____)];

EXCEPT *(check only the items below that should NOT be disclosed, if desired)*:

□ Genetic information, services or tests
□ AIDS or HIV data and records
□ Drug and alcohol data and records
□ Other health information to exclude: _____
□ Mental health data and records
□ Prescription drug/medication data and records

5 This authorization ends on this date/event: _____

Date or specific event when this authorization ends unless cancelled. If this field is blank or does not indicate a specific date/event, the authorization expires one year from the date of the signature below.

6 Member or Representative Signature: _____

Printed Name: _____

Date:_____

If form is signed by the member's legal or personal representative, ***you must send us copies of relevant documents****, such as power of attorney or order of guardianship. This form cannot be accepted without supporting documents.*

Mail completed authorization form and any supporting documentation to
Sunflower Health Plan, Attn: Compliance Department
8325 Lenexa Dr., Ste. 410, Lenexa, KS 66214

KDHE-Approved 8/8/2024

Additional Individual Person(s) or Group(s) to Receive Information:

NOTE: If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, "recipient entity"), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

Name (individual or entity): ______________________________

Address: ______________________________

City: __________ State: __________ Zip: __________ Phone: __________

Name (individual or entity): ______________________________

Address: ______________________________

City: __________ State: __________ Zip: __________ Phone: __________

Name (individual or entity): ______________________________

Address: ______________________________

City: __________ State: __________ Zip: __________ Phone: __________

Name (individual or entity): ______________________________

Address: ______________________________

City: __________ State: __________ Zip: __________ Phone: __________

Name (individual or entity): ______________________________

Address: ______________________________

City: __________ State: __________ Zip: __________ Phone: __________

Name (individual or entity): ______________________________

Address: ______________________________

City: __________ State: __________ Zip: __________ Phone: __________

Name (individual or entity): ______________________________

Address: ______________________________

City: __________ State: __________ Zip: __________ Phone: __________

Name (individual or entity): ______________________________

Address: ______________________________

City: __________ State: __________ Zip: __________ Phone: __________