Healthy Athletes

Authorization for the Disclosure of Health Care Information

Special Olympics
Kansas

I authorize Special Olympics Kansas to disclose my health care information that Special Olympics

Kansas received from my Health Athletes Program health screening to my KanCare Health Provider should I require any additional treatment or follow-up care based on the results of the screening.

I understand that Special Olympics Kansas will provide the Health Athletes Program health screening, regardless of whether or not I sign this authorization.

I understand that any health care information disclosed pursuant to this authorization may be subject to re-disclosure by the KanCare Health Provider. I understand that if my health care information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may not be protected by HIPAA.

I understand that I may revoke this authorization at any time. My revocation must be in writing and include my name, address, telephone number, date of this authorization and my signature, and be sent to the following: SOKS: 5280 Foxridge Dr., Mission, KS 66202 Attn: Healthy Athletes. My revocation will be effective upon Special Olympics Kansas' receipt of such revocation, but will not be effective to the extent that Special Olympics Kansas or others have acted in reliance on this authorization.

I understand that I have the right to inspect and copy the information that is being disclosed to my KanCare Health Provider. I understand that I have the right to receive a copy of this form.

By signing below, I agree that I have read and understand this authorization and I authorize the disclosure described herein.

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Athlete's Printed Name

____ _________________________

Athlete's Signature (18 years old or older) Date

IF ATHLETE IS UNDER 18, PARENT/LEGAL GUARDIAN MUST READ AND SIGN BELOW:

I am the parent / legal guardian of the above named athlete and have carefully read the above authorization. I hereby authorize the disclosure of health information on behalf of the named athlete pursuant to the terms and conditions set forth above.

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Parent or Guardian Printed Name

____ _________________________

Parent or Guardian's Signature Date

Select your KanCare Health Provider

_____ Amerigroup
_____ Sunflower Health Plan
_____ United Healthcare

For additional Info please contact:
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