KANSAS CITY LIFE INSURANCE COMPANY
3520 Broadway / Box 219139 / Kansas City, Missouri 64141-6139
Telephone: (877) 266-6767 / Fax: (816) 753-2964

AUTHORIZATION FORM

I hereby authorize disclosure of protected health information of (name, SSN and any other data needed to identify the individual):

If this Authorization applies to all protected health information, check here: ( )
If this Authorization applies to less than all protected health information, describe below the information to which the Authorization applies:

My protected health information may be disclosed to the following person(s), organization(s), or classes of persons or organizations:

My protected health information may be disclosed by any or all of the following:

Kansas City Life Insurance Company, KCL Group Benefits and/or My Employer (employer name below)

Working on my behalf to resolve claims issues.

This Authorization will expire on (select one):
( ) The following date: _____
( ) When the records covered by this Authorization have been provided.
( ) On occurrence of the following event:

I understand that:

I may revoke this Authorization at any time by sending or delivering a written notice of revocation to: Kansas City Life, KCL Group Benefits PO Box 219425, Kansas City, MO 64121-9425, Attn HIPAA Revocation and to my Employer. The revocation will be effective on the date received. It will not apply to any actions taken in reliance on this Authorization before that date.

My decision to give this Authorization is voluntary. However, if the Authorization is given to enroll in a health plan, obtain health insurance or adjudicate a claim for benefits, my refusal to give the authorization could result in dis-enrollment from the health plan or declination of health insurance coverage or of my claim for benefits.

If any of the persons or organizations identified above are health care providers, health care clearinghouses or health care plans, my protected health information may no longer be protected by federal law and the recipient could re-disclose it.

I am entitled to a copy of this Authorization after I sign it.

Signature:_____ Date:_____

Print Name: _____
If you are signing as a personal representative, state your relationship to the person whose protected health information is the subject of this Authorization:

Is this authorization for disclosure of psychotherapy notes? (Circle one) Yes No
If so, you may not use it for disclosure of any other health information.