

Authorization for the Release of Protected Health Information to Agents of Record

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| Patient Name: _____ |
| Social Security Number: _____ |
| Date of Birth: _____ |
| Policy Number: _____ |

I, _____, hereby authorize _____ (Company Name) to disclose my protected health information (PHI), as described in more detail in the paragraphs below, to the Agent of Record/Broker:

Name of Person(s) or Organization(s):

I specifically authorize the use and disclosure of the following PHI:

(Specifically describe the protected health information to be disclosed. Include meaningful descriptors such as date of service, type of service provided, level of detail to be released, etc.)

This protected health information is being disclosed to obtain the status of claims and policy terms in the following manner:

(Specifically describe how protected health information will be used.)

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

I understand and agree that:

- I have the right to revoke this authorization, in writing, at any time by sending such written notice to the company. A revocation is not effective except to the extent that the company has relied on the disclosure of the PHI (protected health information).
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- The company will not condition my claim processing or eligibility of benefits on whether I provide authorization for the requested disclosure.
- I have the right to refuse to sign this authorization form.

Signature

Date

Description of Personal Representative's Authority