

Senior Health Insurance Company of Pennsylvania Authorization to Release Medical Information

Pursuant to the HIPAA Privacy Rule § 164.508(c)

You have the right to authorize Senior Health Insurance Company of Pennsylvania (Company) to disclose your Protected Health Information (PHI) to anyone you designate and for any purpose. If you want us to communicate with another individual about your policy and allow us to disclose your PHI, please complete the information below. **Completion of this form will not change the way we communicate with you, and will not allow anyone but you to make changes to your policy.**

Name of Insured		Date of Birth
Policy No.	Address	
By my signature below, I authorize Company to disclose my PHI to (enter name of party authorized to receive your PHI)		
Name of Authorized Individual		Relationship to Insured
I authorize Company to disclose the following PHI to the individual/organization listed above:		
<input type="checkbox"/> All Claims Information	<input type="checkbox"/> Eligibility Information	
<input type="checkbox"/> All Benefit Information	<input type="checkbox"/> Explanation of Benefits Information	
<input type="checkbox"/> Premium Payment Information	<input type="checkbox"/> Any Information Requested	
<input type="checkbox"/> Services from a specific health care provider (provider's name): _____		
<input type="checkbox"/> Other (please list specific PHI to be disclosed): _____		
I would like this authorization to <u>EXPIRE</u> on:		
<input type="checkbox"/> This date ____/____/____ OR <input type="checkbox"/> The date my coverage ends		
(If no expiration selection is made, this authorization shall expire twelve (12) months from its date of receipt)		
This authorization shall be effective as of the date of my signature below. I understand that I can revoke this authorization at any time, except to the extent it has already been relied upon, by giving written notice at the following address: <i>Senior Health Insurance Company of Pennsylvania, Attn: Claim Review, P.O. Box 64913, St. Paul, MN 55164.</i>		
I understand that Company may not deny me benefits due to refusal to sign this authorization. I further understand that my signature on this authorization does not authorize any changes to my policy information or to my policy. I also understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by the HIPAA Privacy Rule. The undersigned is entitled to receive a copy of this form. A copy of this authorization shall be as valid as the original.		
Signature of Insured: _____		Effective Date: _____
(If signed by a Legal Representative, please complete the following and attach evidence of legal authority.)		
Your name: _____		
Describe your authority to act on behalf of the insured, e.g., power of attorney, legal guardian, etc.): _____		
Please provide the following information to your designee so we may verify that person's identity: 1) your name; 2) your date of birth; 3) your policy number, and 4) your address of record.	Return to: Senior Health Insurance Company of Pennsylvania Attn: Claim Review P.O. Box 64913 St. Paul, MN 55164	
	Or Fax to: (952) 983-5256	