

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

to an Authorized Individual/Personal Representative



My name is , (policy no.). By my signature below, I hereby authorize the use and disclosure of my protected health information for: coverage administration, billing information, and or claims information, or as defined or limited to the following:

Senior Health Insurance Company of Pennsylvania may release my protected health information as described above to the following person(s):

Name of Individual Authorized to Receive Protected Health Information Phone Number

Address

City State Zip Code

This form is for use and disclosures only. It does not authorize anyone other than me or my legal representative to make any changes to my: coverage, billing or demographic information. I understand if the person or entity receiving my information is not covered by federal privacy regulations, my information may be re-disclosed by such person or entity, and it will no longer be protected.

This authorization is valid until my coverage ends, unless a specific expiration date or event is specified here: _____. I understand that I may revoke this authorization in writing at any time. I am entitled to make a copy of, or request to receive a copy of this authorization.

I understand that I am not required to sign this authorization and that payment or eligibility will not be conditioned upon my choice not to sign. I further understand that my protected health information cannot be disclosed to any unauthorized third party without my signature.

I acknowledge, by my signature below, that I have read and understand this Authorization, it accurately reflects my wishes, and a photocopy, facsimile, or other electronic copy is as valid as the signed original.

Signature of Individual Authorizing Disclosure (or Legal Representative*) Date *Describe source of legal authority:

WE REQUIRE WRITTEN DOCUMENTATION OF LEGAL AUTHORITY PRIOR TO DISCLOSING THE PROTECTED HEALTH INFORMATION OF THE INDIVIDUAL NAMED ABOVE.

*Senior Health Insurance Company of Pennsylvania is formerly known as Consecro Senior Health Insurance Company

RETURN THIS FORM TO: Senior Health Insurance Company of Pennsylvania*

Fax to 952-983-5254, or mail to
P.O. Box 64913 St. Paul, MN 55164