AUTHORIZATION FOR DISCLOSURE OF HEALTH-RELATED INFORMATION

(This authorization complies with HIPAA Privacy Rules.)

Name of Policyholder:	Policy Number:
Address Line 1:	Address Line 2:
City, ST, Zip:	Date of Birth:

NOTE: If this form is completed by a Legal Representative then a valid Power of Attorney, Guardianship, Conservatorship or similar documentation must accompany this form.

Health Information to be Disclosed *by* Senior Health Insurance Company of Pennsylvania
I authorize the Company to disclose my Protected Health Information to the following

(Person/Organization Receiving Information):_____

_____

The Relationship of this person/organization to me is: _____

This recipient may use the health information authorized on this form for the following purpose(s):

_____

_____

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 to: Senior Health Insurance Company of Pennsylvania, *Attn: Claim Review,* PO Box 64913, St. Paul, MN 55164. I understand that the Company may not deny me benefits due to refusal to sign this authorization. I further understand that my signature on this form does not authorize any changes to my policy information or to my policy or change the way the Company communicates with me. I also understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. The undersigned is entitled to receive a copy of this form. A photocopy of this authorization shall be as valid as the original.

Policyholder (or Legal Representative)

Signature: X _____ Date: _____

Type of authority to act or sign on behalf of the policyholder (please check box, if applicable):

☐ Legal Representative ☐ Power of Attorney ☐ Guardianship ☐ Conservatorship