HIPAA Authorization for Release of Protected Health Information

ASSURANT Employee Benefits®

Insured/Member name _____ ID no. _____

Address _____ City _____ State _____ Zip code _____

Policy no. _____ Participation no. _____ Account no. _____ Certificate no. _____

Persons/organizations <u>providing</u> the information:

☐ Union Security Insurance Company
☐ Union Security Life Insurance Company of New York
☐ Other *(Please specify.)*

_____

Persons/organizations <u>receiving</u> the information:

☐ Union Security Insurance Company
☐ Union Security Life Insurance Company of New York
☐ Other *(Please specify.)*

_____

I hereby authorize the use of disclosure of my protected health information as described below.

Specific description of information to be disclosed _____

_____

_____

_____

_____

Purpose of the disclosure _____

_____

_____

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only – we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.
- This authorization is effective from the date signed below until _____.
  DATE OR EVENT *(NOT TO EXCEED 24 MONTHS)*

_____ _____
SIGNATURE OF INSURED/MEMBER OR PERSONAL REPRESENTATIVE DATE

(Form MUST be completed before signing.)

Printed name of personal representative _____

Relationship to insured/member _____
(E.G. LEGAL GUARDIAN, POWER OF ATTORNEY, SPOUSE, RELATIVE, ETC.)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

Fax the completed Authorization for processing to 816.881.8854, Attention: HIPAA Specialist.

– or –

Mail the completed Authorization for processing to Privacy Office, Assurant Employee Benefits, P.O. Box 419052, Kansas City, MO 64141-6052.

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company or an affiliated prepaid dental company. In New York, insurance products are underwritten by Union Security Life Insurance Company of New York, which is licensed in New York and has its principal place of business in Syracuse, New York.