HIPAA Authorization for Release of Protected Health Information

ASSURANT Employee Benefits

Insured/Member name ______________________ ID no. ____________

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.)*

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

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

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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:

- This authorization is voluntary and I may revoke it at any time by contacting Assurant Employee Benefits at P.O. Box 419052, Kansas City, MO 64141-6052.
- An authorization presented to Assurant Employee Benefits is specifically understood to be a request for information from any individually wholly-owned affiliate of Assurant, Inc.
- I may inspect and/or copy the health information described above.
- The information disclosed may be subject to redisclosure by the recipient and thereby no longer protected by HIPAA.
- I may refuse to sign this authorization and my treatment or payment will not be conditioned on my refusal to sign, unless the authorization is related to treatment related to research.
- I will be informed if the person requesting the information is to receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
- If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.
- I am entitled to receive a copy of this authorization form upon request.
- 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.