MEDAmerica

MedAmerica Insurance Company Home Office: Pittsburgh, PA
MedAmerica Insurance Company of Florida Home Office: Orlando, FL
MedAmerica Insurance Company of New York Home Office: Rochester, NY

("The Company")

AUTHORIZATION FOR HEALTH CARE PROVIDER TO DISCLOSE

PROTECTED HEALTH INFORMATION (PHI) WITH THE COMPANY

☐ **Check here only if you are authorizing access to psychotherapy notes. If checked, this form cannot be used for any other purpose.**
You must complete a separate form for authorizing access to any other information. If this box is checked, skip Part D.

PLEASE PRINT

PART A: INSURED'S INFORMATION TO BE DISCLOSED

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	IDENTIFICATION #

CURRENT ADDRESS	CITY	STATE	ZIP

PART B: ENTITY AUTHORIZED TO RELEASE INFORMATION TO THE COMPANY (PLEASE CHECK ONE)

☐ I authorize any physician, medical practitioner, hospital, clinic, other health care provider or health-care facility, insurance or reinsuring company or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to furnish The Company or its designated Business Associate any information needed to determine insurability or eligibility for insurance benefits.

☐ I am authorizing the following Health Care Provider to disclose my protected health information:

Name/Organization:_____Phone #:_____

Address:_____City:_____State:_____Zip:_____

PART C: REASON FOR DISCLOSURE

☐ Any purpose ☐ Specific purpose:_____

PART D: PROTECTED HEALTH INFORMATION TO BE DISCLOSED *(check all that apply)*

☐ Medical records (e.g. physician or hospital records, case management, phone and face-to-face assessment notes, etc.)

☐ Alcohol or substance abuse

☐ Mental health (excluding psychotherapy notes)

PART E: ACKNOWLEDGEMENT (PLEASE READ AND SIGN)

I understand that:

- I can revoke this authorization at any time by writing to the LTC Privacy Officer at PO Box 41090, Rochester, NY 14604. This revocation would not affect any action taken by The Company in reliance on this authorization before my written revocation is received.
- Information disclosed as a result of this authorization may be re-disclosed by the recipient. Federal and state privacy laws may no longer protect my PHI.

IMPORTANT: I have read and understand the terms of this authorization. I hereby authorize the use and disclosure of my protected health information in the manner described in this form. Unless we receive revocation in writing, this authorization will be valid until The Company completes activities outlined in Part C or until the date specified here:____/____/_____

If this request is being completed by the insured, complete the following:

Signature: _____ Date: _____

OR

If this request is from a personal representative on behalf of the insured, complete the following:

Personal Representative's Name: _____

Personal Representative's Signature: _____ Date: _____

Description of Authority ☐ Power of Attorney* ☐ Other* _____

You must provide documentation supporting your legal authority to act on behalf of the insured.

INCOMPLETE FORMS WILL NOT BE PROCESSED – BE SURE TO RETAIN A COPY FOR YOUR RECORDS Jan-25