HCC Medical Insurance Services
251 N. Illinois Street, Suite 600
Indianapolis, Indiana 46204
main 317 262 2132 web www.hccmis.com

AUTHORIZATION FORM FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form authorizes the HCC Medical Insurance Services (HCCMIS) to use and/or disclose your protected health information ("PHI") to individuals you specify. For the purpose of this form, PHI shall be considered protected health information which is individually identifiable health information received from or maintained by HCCMIS. Without a completed and signed authorization form, Federal law prohibits the HCCMIS from releasing your PHI to your spouse, parent, adult children, or other family members or close personal friends unless you are present at the time of disclosure. *No benefits will be withheld from you if you refuse to sign this form. *

SECTION A: Individual authorizing use and/or disclosure.

Insured Name: _____

Policy/Certificate Number: _____

SECTION B: The use and/or disclosure being authorized.

The information to be used and/or disclosed is:

___ Claim & payment data
___ Bills, requests for payment
___ Eligibility and Enrollment
___ Payments or coverage under the Policy / Certificate
___ Other (please specify) _____

_____

Purpose of this use and/or disclosure:

____ At my request
____ Other (please specify) _____

Persons this information may be disclosed to:

1. _____ Relationship to Insured _____
2. _____ Relationship to Insured _____
3. _____ Relationship to Insured _____
4. _____ Relationship to Insured _____

SECTION C: Expiration.

This authorization will expire (complete one):

____ On _____/_____/_____ (month/day/year)
____ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized): _____

_____

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SECTION D: Important Information About Your Rights.

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time by notifying the HCC Medical Insurance Services in writing, but the revocation will not have any effect on any actions that HCC Medical Insurance Services took before we received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits to which I am otherwise entitled.
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity and I understand that the information may no longer be protected by the Health Insurance Portability Accountability Act of 1996 (also known as HIPAA).

INDIVIDUAL'S SIGNATURE

I, having had the full opportunity to read and consider the contents of this authorization, hereby authorize HCC Medical Insurance Services to use and/or disclose my protected health information as indicated above.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the Policyholder / Certificate Holder, complete the following:

Personal Representative's Name: _____

Relationship to Policyholder / Certificate Holder for whom this authorization applies: _____

_____

Note: You must provide valid and current proof of your legal relationship as a personal representative.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
A copy of this form may be used as if it were an original.

Please submit form to:
HCC Medical Insurance Services
ATTN: Claims Department
PO Box 863
Indianapolis, IN 46206