unifiedlife

P.O. Box 25326
Overland Park, KS 66225-5326
1-800-237-4463

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INFORMATION

This authorization must be written, dated, and signed by the Policyholder or by a person authorized by law to give this authorization. File copy and facsimile transmission are considered equivalent to the original (unless applicable state law provides otherwise).

I, or my authorized representative, hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf, to disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records, as described below. I understand these records may contain information created by other persons or entities, including health care providers as well as information recording the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services (Note: psychotherapy notes may be used/disclosed only pursuant to a separate authorization pertaining only to psychotherapy notes), reproductive health services, and treatment for sexually transmitted diseases.

Patient Name:_____ Patient Date of Birth:_____

Policy Number(s):_____

1. Persons/entities authorized to receive the information:_____
2. Type of information the insurer is authorized to use or disclose:
   - ☐ Entire Medical Record, including patient histories, office notes (excluding psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to Unified Life Insurance Company by health care professionals, insurers, other such health care providers.
   - ☐ Other:_____
3. The information will be used or disclosed for the following purposes:_____
4. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my enrollment in the health plan, eligibility to receive benefits, ability to obtain treatment, or ability to receive payment for treatment, unless allowed by law. If I refuse to release my complete medical record, the insurer may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments.
5. I understand that I may revoke this authorization at any time by notifying the insurer in writing at: P.O. Box 25326, Overland Park, KS 66225-5326, Attention: Compliance Manager; except to the extent that:
   a. We have taken action in reliance on this authorization; or
   b. If authorization was obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.
6. This authorization shall remain in force for thirty (30) months following the date of my signature below or unless otherwise stated below:
   This authorization expires [on] [upon]_____[date] or is valid until_____[event].
7. The insurer will not receive compensation from a third party for using or disclosing this information.

I understand that once health information about me has been disclosed by the insurer to a third party, the health information may no longer be protected by federal privacy laws. All items on this form have been completed and my questions about this form have been answered. In addition, I have kept a copy of this form for my records.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction as directed above.

Printed name of Policyholder or Authorized Representative	Relationship to Policyholder and authority to act for Policyholder
Signature of Policyholder or Authorized Representative	Date