AUTHORIZATION FOR USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

to an Authorized Individual/Personal Representative

I, _____, policy number _____, hereby authorize the use and disclosure of my protected health information, as it relates to coverage, billing, and claims administration, or as defined, or as limited to the following:

_____

_____

Continental Casualty Company may release my protected health information as described above to the following person(s):

_____

Printed Name of Authorized Individual Phone Number

_____

Street Address

_____

City State Zip Code

This form is for use and disclosures only. It does not authorize anyone other than me or my legal representative to make any changes to my coverage, billing, or demographic information. I understand that if the person or entity that receives my information is not covered by the federal privacy regulations, my information may be re-disclosed by such person or entity and will then no longer be protected.

This authorization is valid until my coverage ends, unless a specific expiration date or event is specified here: _____. I understand that I may revoke this authorization in writing at any time. I am entitled to make a copy of or request to receive a copy of this authorization.

I understand that I am not required to sign this authorization and that payment or eligibility will not be conditioned upon my choice not to sign. I further understand that my protected health information cannot be disclosed to any unauthorized third party without my signature.

I acknowledge by my signature below that I have read and understand this Authorization, that it accurately reflects my wishes, and that a photocopy, facsimile, or other electronic copy is as valid as the signed original.

_____

Signature of Insured or *Legal Representative Date

*If you are signing as a legal representative, describe the scope of your authority to act on the insured's behalf and include a copy of the documentation of your legal authority.
Fax back to us at 1-952-983-5193