THE AMERITAS ACACIA COMPANIES℠

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

I, the undersigned, hereby authorize _____ and any of its parents, subsidiaries, or affiliates and their respective agents and subcontractors, to disclose confidential health information about the member/insured below.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.

You must complete both sides of this form. Please type or print.

1. Member/Insured Information

Last Name:	First:	M.I.:

Date of Birth:	SS #:	M.I.:

2. I authorize the individual(s) or company(ies) indicated below to receive protected health information regarding the member/insured named above.

Individual/Company Authorized to Receive Protected Health Information:	Daytime Phone:	Fax:

Street Address:	City:	State:	ZIP:

Individual/Company Authorized to Receive Protected Health Information:	Daytime Phone:	Fax:

Street Address:	City:	State:	ZIP:

Individual/Company Authorized to Receive Protected Health Information:	Daytime Phone:	Fax:

Street Address:	City:	State:	ZIP:

3. Purpose for the Release or Disclosure of Information:

☐ Disclosures are made at the request of the member/insured.

☐ Other (Please Specify):

_____

_____

_____

_____

4. Description of the information to be released or disclosed *(Check all that apply)*:

☐ Enrollment Information

☐ Claims Records

☐ Claims Status

☐ Other: _____

(Specifically describe the records to be released)

5. Expiration:

☐ For a period of _____ month(s) from the date of my signature below; **OR**

☐ Until the completion of _____

(Specific event or purpose of the release)

6. IMPORTANT: Your signature below means that you understand and agree to the following:

- **I understand that the Information provided under this authorization may include Protected Health Information which could contain diagnosis and treatment information including information pertaining to chronic and/or communicable diseases including but not limited to: alcohol or drug abuse; psychiatric or mental conditions; HIV or sexually transmitted disease; genetic disorders; and/or Sickle Cell.**
- **I understand that the information to be disclosed is protected by law and that the same information may be redisclosed by the recipient and may no longer be protected by the same law(s) that applied in the first instance.**
- **I understand that I may be charged a reasonable fee (only as allowed by law) for copying and mailing the disclosures to the individual(s) or company(ies) that I have designated in Section 2 above.**
- **I understand that my ability to enroll in an Ameritas Acacia Companies insurance plan, eligibility for benefits and payment for services will not be affected if I do not sign this form. However, I understand that without this completed form with my signature, my request to release the information described above to a third party will not be honored.**
- **I understand that this Authorization is effective until the date or the event indicated in Section 5 above unless I revoke this Authorization before it expires. I understand that I may revoke this Authorization at any time during its effective period by requesting such in writing to the Company at: The Ameritas Acacia Companies, Attn. Privacy Office, P.O. Box 81889, Lincoln, NE 68510-1889.**

A photocopy of this Authorization will be treated in the same manner as the original.

Signature of patient/guardian/personal representative:	Date:

Legal relationship to Patient (Must be completed if signed by guardian or personal representative):