HIPAA Authorization For Release of Health Information

* Required Field

FORTIS
Solid partners, flexible solutions®

Insured/Member name* _____ ID no.* _____

Policy no.* _____ Participation no. _____ Account no. _____ Certificate no. _____

Persons/organizations providing the information:

- ☐ Fortis Benefits Insurance Company
- ☐ First Fortis Life Insurance Company
- ☐ Other *(Please specify.)*

_____

Persons/organizations receiving the information:

- ☐ Fortis Benefits Insurance Company
- ☐ First Fortis Life Insurance Company
- ☐ Other *(Please specify.)*

_____

I hereby authorize the use of disclosure of my protected health information as described below.

Specific description of information to be disclosed _____

Purpose of the disclosure _____

I understand the following:

- This authorization is voluntary and I may revoke it at any time by contacting Fortis Benefits Insurance Company at P.O. Box 419052, Kansas City, MO 64108.
- I may inspect and/or copy the health information described above.
- The information disclosed may be subject to redisclosure by the recipient and thereby no longer protected by HIPAA.
- I may refuse to sign this authorization and my treatment or payment will not be conditioned on my refusal to sign, unless the authorization is related to treatment related to research.
- I will be informed if the person requesting the information is to receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
- If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.
- This authorization is effective from the date signed below until _____.
  DATE OR EVENT

_____ _____

SIGNATURE OF INSURED/MEMBER OR PERSONAL REPRESENTATIVE — DATE

(Form MUST be completed before signing.)

Printed name of personal representative _____

Relationship to insured/member _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION