Mutual of Omaha Life Insurance Company Long-Term Care

THIRD PARTY AUTHORIZATION FORM

for Use and Disclosures of Protected Health Information (PHI) to an Authorized Individual

Instructions: *In order to protect your privacy in compliance with state and federal laws, we cannot disclose your PHI to anyone other than to you, unless you provide authorization. If you would like to authorize anyone for this purpose, please complete and return this form.*

I, _____, Policy/Certificate Number _____, hereby authorize the use and disclosure of my protected health information for: coverage administration, billing information, and/or claims information, or as defined, or as limited to the following:

_____

_____

Mutual of Omaha Life Insurance Company Long-Term Care may release my protected health information as described above to the following individual(s):

_____

Printed Name of Authorized Individual Phone Number

_____

Street Address City State Zip Code

_____

Printed Name of Authorized Individual Phone Number

_____

Street Address City State Zip Code

By signing below, you are agreeing to the following statements:

This form is for use and disclosures only; it does not authorize anyone other than me or my legal representative to make any decisions about, or changes to my: coverage, billing or demographic information. I understand that if a person or entity that receives my information is not covered by 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 acknowledge by my signature below that I have read and understand this Authorization, it accurately reflects my wishes, and a photocopy, facsimile, or other electronic copy is as valid as the signed original.

_____

*Signature of Individual or *Legal Representative* *Date signed (Month, Day, Year)*

**If you are signing as a legal representative, describe the scope of your authority to act on the Individual's behalf and include a copy of the documentation of your legal authority.*