MEDAmerica

MedAmerica Insurance Company
Home Office: Pittsburgh, PA
MedAmerica Insurance Company of New York
Home Office: Rochester, NY
MedAmerica Insurance Company of Florida
Home Office: Orlando, FL

("The Company")

AUTHORIZATION FOR THE COMPANY TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) WITH A THIRD PARTY

☐ **Check here only if you are authorizing access to psychotherapy notes. If checked, this form cannot be used for any other purpose. You must complete a separate form for authorizing access to any other information. If this box is checked, skip Part D.**

PLEASE PRINT

PART A: INSURED'S INFORMATION TO BE DISCLOSED

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	IDENTIFICATION #

CURRENT ADDRESS	CITY	STATE	ZIP

PART B: THE COMPANY CAN SHARE MY INFORMATION WITH THE FOLLOWING PERSON/ORGANIZATION

NAME OF PERSON/ORGANIZATION	RELATIONSHIP	PHONE #

ADDRESS	CITY	STATE	ZIP

PART C: REASON FOR DISCLOSURE (PLEASE CHECK ONE)

☐ Third party can access information for any purpose.

☐ Third party can access PHI to a specific provider, condition And/or date(s). Please specify below:
Provider: _____
Condition: _____
Date(s): _____ to _____

PART D: THE COMPANY CAN SHARE THE FOLLOWING INFORMATION

NOTE: Skip this section if psychotherapy was checked at the top of this form

☐ Any information (e.g. medical records, claim information, benefit information, etc.)

☐ Other: _____
_____

PART E: ACKNOWLEDGEMENT (PLEASE READ AND SIGN)

I understand that:

- I can revoke this authorization at any time by writing to the LTC Privacy Officer at the address listed below except this revocation would not affect any action taken by The Company in reliance on this authorization before my written revocation is received.
- Information disclosed as a result of this authorization may be re-disclosed by the recipient. Federal and state privacy laws may no longer protect my PHI.

IMPORTANT: I have read and understand the terms of this authorization. I hereby authorize the use and disclosure of my protected health information in the manner described in this form. Unless we receive revocation in writing, this authorization will be valid until The Company completes activities outlined in Part C or until the date specified here: ____/____/____

If this request is being completed by the insured, complete the following:

Signature: _____ Date: _____

OR

If this request is from a personal representative on behalf of the insured, complete the following:

Personal Representative's Name: _____

Personal Representative's Signature: _____ Date: _____

Description of Authority ☐ Power of Attorney* ☐ Other* _____

You must provide documentation supporting your legal authority to act on behalf of the insured.

INCOMPLETE FORMS WILL NOT BE PROCESSED – BE SURE TO RETAIN A COPY FOR YOUR RECORDS

Return form to: PO Box 41090, Rochester, NY 14604
1-800-544-0327