HIPAA INSTRUCTIONS

The attached authorization form is being sent to you because we have received a request from you to discuss your policy and/or your private health information with another party other than yourself. In order for us to be protect your information and remain compliant under the provisions of the Health Information Portability Accountability Act (HIPAA), the attached form must be completed and returned to us before we can discuss your policy and/or private health information as requested.

For your convenience, we have partially completed the form. Please carefully check those sections completed by us and make any necessary corrections by crossing through the error, writing in your correction then initial and date the correction.

You must complete the following areas before we can release your information.

Under Section C:

Purpose of the Authorization by checking the two boxes and providing the purpose of our release of your policy and/or private health information,

Specifically describe the protected health information to be used and/or disclosed.

Please indicate who you would like to authorize under section titled “entities or persons authorized to receive and use”.

Under Section D:

Please indicate a specific termination date of the authorization by checking the first box and providing the appropriate date, or

Please check the second box and specify a particular event describing the termination of the authorization to release information to the party indicated to receive information of your behalf. An example of a particular event is “Termination of Policy”.

Please remember to execute the authorization by signing and dating the form under Individual’s Signature.

You may return the fully completed form to us by fax 281-368-7358/ 281-368-7382 or by mail to the address on the form.

If you have any questions, please do not hesitate to contact our Customer Service Department at 888-748-3040.

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY℠

THIS IS A SAMPLE ONLY

11720 Katy Fwy., Ste. 1700 • Houston, Texas 77079 • (800) 552-7879

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

Purpose: This form is used for an individual to authorize use or disclosure of the individual's protected health information for the purposes stated.

SECTION A: Psychotherapy notes.

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

SECTION B: Individual authorizing use and/or disclosure.

Member's name
Name

Member's social number
Social Security Number

Member's policy number
Policy / Certificate #

Member's address
Address (Street, City, State, Zip)

Member's phone number
Telephone

Member's email
E-mail

TO THE INDIVIDUAL: Please read the following and complete the information requested.

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan or eligibility for benefits on receiving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION C: The use and/or disclosure being authorized

Purpose of this Authorization:

☒ At request of individual (or the individual's personal representative)

☒ For the following purposes:

To assist with claims.

Protected Health Information to be Used and/or Disclosed: Specifically and meaningfully describe the protected health information that this authorization will allow to be used and/or disclosed:

Claims assistance.

Entities Authorized to Use or Disclose: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who will be authorized to make use of and/or disclose the protected health information described above:

PALIC

please write below who you would like the authorize to have access to your claims and benefits information

★ Entities or Persons Authorized to Receive and Use: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, whom this authorization will allow to receive and use the protected health information described above:

First and last name of the person you wish to give authorization to and description of said person

Example: John Doe - agent _____ _____

SECTION D: Expiration and revocation.

Expiration: This authorization will expire (complete one): Please mark one of the following:

☐ On ___/___/___

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

_____

_____

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the home office of Philadelphia American Life Insurance Company or the Contact Office listed below. Revocation of this authorization will *not* affect any action we took in reliance on this authorization before we received your written notice of revocation.

Contact Office: _____

Optional Section

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

INDIVIDUAL'S SIGNATURE

I, Member's name _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Member's signature _____ Date _____

Signature Date

If this authorization is signed by a personal representative on behalf of the individual, complete the following: If applicable

_____ _____

Personal Representative: Print Name

Please indicate Representatives relationship to Applicant/Insured and briefly describe Representatives authority to act for Applicant/Insured.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's records.

Send copy to the Privacy Official.

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY℠

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SECTION A: Psychotherapy notes.

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

SECTION B: Individual authorizing use and/or disclosure.

Name _____ Social Security Number _____ Policy / Certificate # _____

Address (Street, City, State, Zip) _____

Telephone _____ E-mail _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan or eligibility for benefits on receiving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

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☒ For the following purposes:

To assist with claims

Protected Health Information to be Used and/or Disclosed: Specifically and meaningfully describe the protected health information that this authorization will allow to be used and/or disclosed:

Claims assistance

Entities Authorized to Use or Disclose: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who will be authorized to make use of and/or disclose the protected health information described above:

PALIC

Entities or Persons Authorized to Receive and Use: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, whom this authorization will allow to receive and use the protected health information described above:

_____ _____

_____ _____

SECTION D: Expiration and revocation.

Expiration: This authorization will expire (complete one):

☐ On ___/___/___

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

_____

_____

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Contact Office: _____

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E-mail: _____

Address: _____

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Signature Date

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

_____ _____

Personal Representative: Print Name Please indicate Representatives relationship to Applicant/Insured and briefly describe Representatives authority to act for Applicant/Insured.

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