Relation™

HIPAA Authorization for Use and Disclosure of Information

I hereby authorize the use and/or disclosure of my individually identifiable health information (the "Information") as follows:

In connection with the insurance claim on the accompanying Proof of Loss Form dated _____ (the "Claim"), I authorize my health care providers to disclose to Relation Insurance Services, my sponsoring college or university, my named parent(s) or guardian(s) and/or any insurance companies to whom the claim may be submitted (a payor), all information related to the claim, for the specific purposes of facilitating the processing and/or payment of the claim by Relation Insurance Services and communicating with Relation Insurance Services and the payor about the claim.

This authorization is specifically limited to the individually identifiable health information related to the claim.

I further understand and agree:
1. This authorization will expire upon the termination of the insurance policy between my sponsoring college or university and the payor.
2. I may revoke this authorization at any time by notifying Relation Insurance Services in writing (although the revocation will not have any effect on any actions taken before receiving the revocation).
3. I may see and copy the information described on this form if I ask for it.
4. I am not required to sign this form in order to receive health care services from my provider.
5. The information that is used or disclosed under this authorization may be re-disclosed by the receiving entities, but only for the specific purposes authorized.

Parent(s)/Guardian(s) Names: _____

If I am signing this Authorization as a Claimant's Representative, I certify that I have the authority to act on behalf of the Claimant and that the information provided below to verify my identity is correct.

_____
Signature of Claimant or Claimant's Representative

_____
Date

Name of Claimant's Representative, if applicable:_____

Representative's DOB:_____ Relationship to the Claimant _____