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.

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.

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:

____________________________________ ____

____________________________________ ____

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):

____

____

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: ____

Telephone: ____________________________________ Fax: __________________________________

E-mail: ____

Address: ____

INDIVIDUAL'S SIGNATURE

I, ____________________________________, 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.

____	____
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.

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.