

**AUTHORIZATION FOR THE USE OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

I \_\_\_\_\_ hereby authorize my Protected Health Information,  
(Print Name)

**I.** Described as follows: (Specifically describe the Protected Health Information to be used or disclosed)

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**II.** Initial Here \_\_\_\_\_ to authorize representatives of Assurity Life Insurance Company/Group Marketing Services, Inc. to make the requested use or disclosure of your Protected Health Information.

**III.** List the name of the person(s) you have authorized to use or disclose your Protected Health Information. Please also list this person(s) relationship to you, i.e. spouse, attorney, etc.  
(This person will also need to sign the bottom of this form in the space marked Authorized Representative):

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**IV.** List a description of each purpose of the requested use or disclosure, the statement "at the request of the individual" is sufficient when the individual initiates an Authorization and does not, or elects not to, provide a statement of the purpose:

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**V.** This Authorization shall expire on the following date or event that relates to the individual or the purpose of the use or disclosure, (e.g. end of research study):

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**VI.** I understand that I have the right to revoke this Authorization in writing and acknowledge that Assurity Life Insurance Company/Group Marketing Services, Inc. will use or disclose my Protected Health Information in reliance upon this Authorization.

**VII.** By signing this Authorization, I acknowledge that I have read and understand this Authorization and I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Representative Signature

\_\_\_\_\_  
Date

## **AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

### **Procedure for Revocation of an Authorization**

- Upon request, our plan will provide a Revocation of Authorization Form to any individual seeking to revoke a previously signed Authorization Form. Upon receipt of a signed and dated Revocation of Authorization Form, we will terminate all uses and disclosure of the individual's Protected Health Information covered by the specific Authorization that is revoked. The revocation will be effective on the date that the signed form is received or the date specified on the form, whichever is later and shall not apply to information used or disclosed prior to the individual's revocation.
- This revocation must be signed and dated by the patient or the patient's authorized Personal Representative.
- The signature must be identified as that of the Patient or the Patient's authorized Personal Representative. If the person signing the Authorization is the Patient's authorized Personal Representative, then the appropriate authorizing law or reason must be noted on the form.

An individual may not revoke his or her authorization to the extent of previously authorized uses or disclosures of the individuals Protected Health Information that relied on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage and other law provides the owner with the right to contest a claim under the policy, or the policy itself.

Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the law will no longer protect the privacy of my Protected Health Information.

Our plan may not condition, or refuse treatment, payment, and enrollment in the health plan, or eligibility for benefits on the provision of obtaining a signed authorization from an individual except for the following:

1. Our plan may condition the provision of research-related treatment on provision of a signed authorization from an individual.
2. A health plan may condition, and deny enrollment in the health plan or eligibility for benefits on provision of an authorization requested by the health plan prior to an individual's enrollment in the health plan, if the authorization sought is for the health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations and the authorization is not for a use or disclosure of psychotherapy notes.
3. Our plan may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.