Student Insurance Plan

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION NEEDED TO ASSIST IN THE DETERMINATION OF THE STATUS OF CLAIM FILED AGAINST THE STUDENT MEDICAL INSURANCE POLICY

I hereby authorize Associated Insurance Plans International, Inc. to obtain and disclose Protected Health Information and disclose such information to the individual(s) indicated Below, for the express and limited purpose of assisting in the processing of my claim.

Please select all applicable fields:

Information to Be Used or Disclosed May Include:

( ) Provider Name, Address & Speciality (required)
( ) Dates of Service (required)
( ) Cost of Service (required)
( ) Medical Diagnosis (optional)
( ) Services Rendered (optional)
( ) Medications (optional)

Persons or Class of Persons to Whom the Disclosure May Be Made:

( ) Student Health Service Staff
( ) Student Affairs Staff
(X) Associated Insurance Plans and staff
( ) A Specific Individual, as follows:_____

I understand that individually identifiable health information relating to me, which is called Protected Health Information as defined by the Privacy Policy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and,

that if the person or entity that receives this information is not a health plan, health care clearinghouse, or health care provider as defined in the regulation text of the Privacy Rule, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law; and,

that I may revoke the authorization at any time by notifying Associated Insurance Plans International, Inc. in writing. However, if I choose to do so, my revocation will not affect any actions taken by Associated Insurance Plans International, Inc. prior to my revocation; and,

that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Insured Student Name: _____
(please print clearly)

Student ID or Social Security Number:_____ Date of Birth: _____

Claimant is: ( ) Self ( ) Dependent (please print full name and indicate relationship)

_____

Patient's or Authorized Representative's Signature: _____

Date: _____ If Authorized Representative, Relationship to Patient: _____