

American Bankers Life Assurance Company of Florida

P.O. Box 977122, Miami, FL 33157 • 1.800.327.5288 • Fax 1.305.252.6910

Authorization for Release of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) requires us to get your written permission to obtain specific health information about you. We are requesting this information in order to process the claim you are presenting to our company. Therefore, please complete in detail, sign, date, and return the following form to us. We cannot process your claim until we have this form returned to us.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY

I hereby authorize the medical providers listed below to release the following.

INSURED INFORMATION			
NAME	SOCIAL SECURITY NUMBER - -	BIRTH DATE / /	DAYTIME TELEPHONE NUMBER ()
STREET ADDRESS	CITY	STATE	ZIP CODE
MEDICAL PROVIDER (doctor, hospital, etc.) WHO I AUTHORIZE TO RELEASE MY PERSONAL INFORMATION:			
NAME	TELEPHONE NUMBER ()		
STREET ADDRESS	CITY	STATE	ZIP CODE
DESCRIPTION OF INFORMATION TO BE RELEASED			
ENTIRE MEDICAL RECORD <input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS TEST RESULTS OR DIAGNOSIS AND TREATMENT <input type="checkbox"/> Yes <input type="checkbox"/> No		
OTHER			
I UNDERSTAND THAT:			
<p>a. This Authorization may be revoked by me at any time by writing to the company and clearly stating that I wish to revoke this Authorization.</p> <p>b. 1. This Authorization will expire without any action by me one year after the date of my signing below. 2. This Authorization shall be valid for the duration of the claim (Arizona residents only).</p> <p>c. Revocation will not apply to my insurance company when the law provides my insurance company the right to contest a claim under my policy.</p> <p>d. This authorization is voluntary and I have the right to refuse to sign it.</p> <p>e. If I revoke this information, it will not apply to information that has already been released prior to my revocation.</p> <p>f. Information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.</p> <p>g. Information released by this authorization may be subject to redisclosure by the recipient and may not be protected any longer by the HIPAA Privacy Rule.</p> <p>h. I agree that a photocopy of this authorization shall be as valid as the original.</p> <p>i. I, or my authorized representative, have the right to receive a copy of this authorization.</p>			
WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals, for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and substantial civil penalties. For other Fraud Statements see Page 2.			
YOUR SIGNATURE (INSURED OR LEGAL REPRESENTATIVE) X			DATE / /

AND if signing on behalf of a minor or as legal representative of another:

NAME OF PERSON YOU ARE SIGNING FOR (PROOF OF YOUR AUTHORIZATION MAY BE REQUIRED)
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ONE FORM MUST BE COMPLETED FOR EACH MEDICAL PROVIDER

Please photocopy this form if you need additional copies.

For Florida Only: - Pursuant to § 817.234, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree, punishable as provided in § 775.082, § 775.083, or § 775.084, Florida Statutes.

OK residents only: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TX residents only: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.