

("The Company")

## AUTHORIZATION FOR THE COMPANY TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) WITH A THIRD PARTY

Check here only if you are authorizing access to psychotherapy notes. If checked, this form cannot be used for any other purpose. You must complete a separate form for authorizing access to any other information. If this box is checked, skip Part D.

**PLEASE PRINT**

PART A: INSURED'S INFORMATION TO BE DISCLOSED					
LAST NAME	FIRST NAME	MI	DATE OF BIRTH	IDENTIFICATION #	
CURRENT ADDRESS			CITY	STATE	ZIP
PART B: THE COMPANY CAN SHARE MY INFORMATION WITH THE FOLLOWING PERSON/ORGANIZATION					
NAME OF PERSON/ORGANIZATION			RELATIONSHIP	PHONE #	
ADDRESS			CITY	STATE	ZIP
PART C: REASON FOR DISCLOSURE (PLEASE CHECK ONE)					
<input type="checkbox"/> Third party can access information for any purpose. <input type="checkbox"/> Third party can access PHI to a specific provider, condition and/or date(s). Please specify below: Provider: _____ Condition: _____ Date(s): _____ to _____					
PART D: THE COMPANY CAN SHARE THE FOLLOWING INFORMATION					
NOTE: Skip this section if psychotherapy was checked at the top of this form					
<input type="checkbox"/> Any information (e.g. medical records, claim information, benefit information, etc.)			<input type="checkbox"/> Other: _____ _____		
PART E: ACKNOWLEDGEMENT (PLEASE READ AND SIGN)					
I understand that: <ul style="list-style-type: none"> <li>• I can revoke this authorization at any time by writing to the LTC Privacy Officer at the address listed below except this revocation would not affect any action taken by The Company in reliance on this authorization before my written revocation is received.</li> <li>• Information disclosed as a result of this authorization may be re-disclosed by the recipient. Federal and state privacy laws may no longer protect my PHI.</li> </ul> <p><b>IMPORTANT: I have read and understand the terms of this authorization. I hereby authorize the use and disclosure of my protected health information in the manner described in this form. Unless we receive revocation in writing, this authorization will be valid until The Company completes activities outlined in Part C or until the date specified here: ____/____/____</b></p> <p>If this request is being completed by the insured, complete the following:            Signature: _____ Date: _____</p> <p style="text-align: center; font-size: 24pt;"><b>OR</b></p> <p>If this request is from a personal representative on behalf of the insured, complete the following:            Personal Representative's Name: _____            Personal Representative's Signature _____            Description of Authority <input type="checkbox"/> Power of Attorney* <input type="checkbox"/> Other* _____</p> <p style="text-align: center;"><b><i>*You must provide documentation supporting your legal authority to act on behalf of the insured.</i></b></p>					

**INCOMPLETE FORMS WILL NOT BE PROCESSED – BE SURE TO RETAIN A COPY FOR YOUR RECORDS**

Return form to:

PO Box 41090, Rochester, NY 14604

1-800-544-0327

Jan-17