Authorized Representative Form

Complete and mail this form to:
Assurant Health, PO Box 354, Milwaukee, WI 53201-0354
or as otherwise directed

ASSURANT Health

This form is used to confirm a Member's permission that Assurant Health* may discuss or disclose his/her protected health information to a particular person who acts as his/her Authorized Representative. Use of his/her information is strictly limited to that purpose described below.

Section A: Member Information

By signing this form in Section E below, I understand and agree that Assurant Health may release my personal health information as defined in Section B below to my Authorized Representative(s) named in Section C below.

Member Name:

Address:

Telephone Number: Member ID Number:

Last (4) Digits of Social Security Number:

Section B: Type of Information

- Personal Health Information, including, but not limited to, identification of treating providers of care, diagnoses, procedures, demographic information (but not including any psychotherapy notes).

Section C: Authorized Use and / or Disclosure

Intended Use or Disclosure:

I understand that your general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my personal health representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Authorized Representative:

Name: **Phone Number:**

Address:

Relationship to You:

Section D: Expiration and Revocation

This authorization to release information to my Authorized Representative will automatically expire one year following the termination of my relationship with Assurant Health.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person(s) named in Section C to remain my Authorized Representative, I must revoke this authorization in writing by giving written notice of my decision to the Privacy Office, Assurant Health, P.O. Box 3050, Milwaukee, WI 53201-3050. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it.

Section E: Signature / Authorization

I have had full opportunity to read and consider the content of this Authorized Representative Form. I confirm that this authorization is consistent with my request. I understand that, by signing this form, I am confirming my authorization that Assurant Health may use and/or disclose my personal health information to the person(s) named in Section C for the purpose described above.

Signature: Date:

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT.

* Assurant Health is the brand name for products underwritten and issued by Time Insurance Company, Union Security Insurance Company, and John Alden Life Insurance Company.
Form 28315 (Rev. 7/2008)

AUTHORIZED REPRESENTATIVE FORM

PLEASE RETURN THE SIGNED AUTHORIZATION FORM TO THE CONTACT PERSON LISTED BELOW.

Contact person:

Name: _____

Address: _____

Fax: _____