

HIPAA Authorization for Release of Protected Health Information— California Residents



Insured/Member name _____ ID no. _____
Policy no. _____ Participation no. _____
Account no. _____ Certificate no. _____

Persons/organizations providing the information:

- Union Security Insurance Company
- Union Security Life Insurance Company of New York
- Other (*Please specify.*) _____

Persons/organizations receiving the information:

- Union Security Insurance Company
- Union Security Life Insurance Company of New York
- Other (*Please specify.*) _____

I hereby authorize the use of disclosure of my protected health information as described below.

Specific description of information to be disclosed _____

Purpose of the disclosure _____

I understand the following:

- This authorization is voluntary and I may revoke it at any time by contacting Assurant Employee Benefits at P.O. Box 419052, Kansas City, MO 64108.
- An authorization presented to Assurant Employee Benefits is specifically understood to be a request for information from any individually wholly-owned affiliate of Assurant, Inc.
- I may inspect and/or copy the health information described above.
- The information disclosed may be subject to redisclosure by the recipient and thereby no longer protected by HIPAA.
- I may refuse to sign this authorization and my treatment or payment will not be conditioned on my refusal to sign, unless the authorization is related to treatment related to research.

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company or an affiliated prepaid dental company. In New York, insurance products are underwritten by Union Security Life Insurance Company of New York, which is licensed in New York and has its principal place of business in Syracuse, New York.

- I will be informed if the person requesting the information is to receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
- If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.
- I am entitled to receive a copy of this authorization form upon request.
- This authorization is effective from the date signed below until _____.

DATE OR EVENT (NOT TO EXCEED 24 MONTHS)

SIGNATURE OF INSURED/MEMBER OR PERSONAL REPRESENTATIVE

DATE

(Form MUST be completed before signing.)

Printed name of personal representative _____

Relationship to insured/member _____

(E.G. LEGAL GUARDIAN, POWER OF ATTORNEY, SPOUSE, RELATIVE, ETC.)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Fax the completed Authorization for processing to 816.881.8854,
Attention: HIPAA Specialist

– or –

Mail the completed Authorization for processing to
Privacy Office, Assurant Employee Benefits,
P.O. Box 419052, Kansas City, MO 64141-6052