

Instructions and Helpful Hints for Completing the HIPAA Authorization for Release of Protected Health Information

Below are instructions on how to properly complete a HIPAA authorization. An authorization that is not filled out properly or that is incomplete may delay processing of your authorization and the release of requested information.

(1) Please tell us who is the insured member and the name of the individual who is the subject of the protected health information (PHI).

a. Insured/member name _____

The name of the individual to whom the policy or certificate is issued and the name of the individual who is the subject of the PHI.

- ▶ If you have insurance through your employer, write the name of the covered employee here.
- ▶ If a spouse, domestic partner (if applicable), or emancipated dependent child is asking about information relating to another dependent, please show both names.

Include a daytime telephone number where the individual who is the subject of the PHI can be reached.

b. ID no. _____

Individual member or group policy number.

c. Participation no. _____

Group (employer) participation number, if applicable.

d. Account no. _____

Group account number, if applicable or available.

e. Certificate no. _____

Group insured's identification number or certificate of insurance number. If unknown, you may put your Social Security number here.

(2) Please tell us who is providing the information and who you want to receive the information. Then tell us what information you want us to share and why you want us to share it.

a. Persons/organizations providing the information

Who has the information? Here are the choices:

- Union Security Insurance Company
- Union Security Life Insurance Company of New York
- Other _____

Check one of the boxes or fill out "Other." Other can be one of the prepaid dental companies, treating dentists, hygienist, medical doctor, hospital, treatment facilitate, etc. (This information has been filled out for you on some authorizations.)

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.

b. Persons/organizations receiving the information

Who is receiving the information? Here are the choices:

- Union Security Insurance Company
- Union Security Life Insurance Company of New York
- Other _____

Check one of the boxes or fill out "Other." If you check "Other," please be specific. Include the name of the person, their organization, or the agency they represent (if applicable), and a telephone number.

Example: Jane Smith, HR, Doe Corporation; Martin Jones (broker); Jones & Jones Agency; Dr. Michael Smith; My wife (June Royal); etc. (On some authorizations, this information has been filled out for you on the authorizations used for life and disability.)

c. Specific description of information to be disclosed

What information do you want the person/organization to receive? Please be specific. For example: dental records, chart notes, clinical examination findings/diagnoses, radiographs, treatment plans, claims submissions, information on a claim with a date of service of 10-04-2003, any information to help me resolve my claims, etc.

d. Purpose of disclosure

Why do you want us to give (or receive) your information to a particular person or organization? For example: Help resolve a denied claim, to determine eligibility, make determination of benefits, adjudicate a claim, resolve a complaint, to answer questions about my claim, etc.

(3) You must read carefully each of the following bullets:

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only – we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.

(4) Please tell us how long you want the authorization to be effective, then sign and date it. (Note: the person who signs the authorization must be the person whose information will be released/disclosed.)

a. Authorization effective date

“This authorization is effective from the date signed below until _____.” The date cannot be more than 24 months from the date the authorization is signed.

b. Signature _____

The person who is the subject of the information to be released must sign the authorization unless the person is represented by a personal representative.

c. Date _____

This date must be the date you signed the authorization.

d. There are times when a personal representative will assist someone with their medical affairs, for example, elderly and disabled individuals. If applicable, please complete the following:

Include signature of the personal representative _____

Relationship of personal representative to the person _____

If you have a power of attorney or other court order applicable to authorization, please mail or fax a copy of it with the completed authorization.

e. 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