# AUTHORIZATION TO RELEASE POLICY INFORMATION

This is a HIPAA Compliant Authorization

Policyholder Name (Please Print): _____

Policy Number: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

_____

I authorize the above listed Company to release information about my insurance policy and claim including my medical care and treatment and other non-medical information as deemed necessary to the following individuals. The information to be disclosed under this authorization may be provided by telephone, mail or facsimile.

**Financial Health Services, LLC**
**450 S. Gravers Road, Suite 220**
**Plymouth Meeting, PA 19462**
484-674-3760

The information to be disclosed under this authorization is defined below:

- Information regarding my policy benefits including but not limited to: daily, weekly, or monthly policy maximum, overall policy maximum, remaining balance information, policy requirements for coverage.
- Information regarding my claims, including but not limited to: payment of claims and claims status

This authorization shall take effect immediately and shall remain in effect for the life of my coverage or earlier at the date stated here: _____. A copy of this authorization may be used in place of the original.
I understand that I have the right to revoke my authorization at any time, except to the extent that it has been relied on already. Revocation requests must be sent in writing to the above Insurance Company's address. I understand that the information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and is no longer protected by the HIPAA privacy rule. If this authorization is for someone other than myself, that individual and my authority to act on his/her behalf are explained below. The undersigned is entitled to a copy of this form.

_____ _____
**Signature of Individual Named Above (Insured)** **Date**

***If Signed by Personal Representative Instead of Individual Named Above:***

_____
**Name of Representative (Please Print)**

_____
**Relationship of Representative to Individual (e.g. Spouse, Power of Attorney, Guardian)**

_____ _____
**Signature of Representative Described Above** **Date**