ADMINISTRATIVE CONCEPTS, INC.

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION NEEDEDTO ASSIST IN THE PROCESSING OF A CLAIM FILED UNDER THE INSURANCE POLICY

I hereby authorize Administrative Concepts, Inc. to obtain **Protected Health Information** and to disclose such PHI tothe individual(s) or entity(ies) indicated below, for the *express* and *limited* purpose of assisting in the processing of myclaim.

Information to be Used or Disclosed May Include:

[ ] Provider name, address & specialty (required)
[ ] Dates of service (required)
[ ] Cost of services (required)
[ ] Medical diagnosis (optional)
[ ] Services rendered (optional)
[ ] Medications (optional)

Persons or Class of Persons to Whom the Disclosure May be Made:

[ ] Student Health Service Staff
[ ] Student Affairs Staff
[ ] Employer
[ ] Association Representative
[ ] A Specific Individual, as follows: _____

I understand that individually identifiable health information relating to me, which is called *Protected Health Information* as defined by the *Privacy Rule* of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA);* and,
that if the person or entity that receives this information is not a business associate, health plan, health care clearinghouse, or health care provider as defined in the *HIPAA Privacy Rule*, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law; and,
that I may revoke the authorization at any time by notifying Administrative Concepts, Inc. *in writing*. However, if I choose to do so, my revocation will not affect any actions taken by Administrative Concepts, Inc. *prior* to my revocation; and,
that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.
This authorization expires 365 days after signing or upon my request to Administrative Concepts, Inc. to terminate the authorization, whichever is earlier.

Insured Member's Name: (print)

Member ID Number _____ Date of Birth: ____/____/____

Claimant is: [ ] Self [ ] Dependent (print full name and indicate relationship to insured)

_____

Patient's or Authorized Representative's Signature:

Date: ____/____/____ If Authorized Representative, Relationship to Patient:_____

Nothing contained in this letter should be construed as a waiver of any rights or defenses under the policy and the applicable law. This determination has been made in good faith and without prejudice under the terms and conditions of the contract, whether or not specifically mentioned herein. Neither this communication nor any further communications that we may have regarding this claim should be construed to waive any of these rights and defenses. We are willing to review any additional information that you may provide. We further reserve all of our rights to assert defenses based upon other policy provisions and applicable law, whether or not specifically mentioned herein.