
AUTHORIZATION TO REQUEST MEDICAL RECORDS

EXPLANATION

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the federal HIPAA privacy regulations, 45 C.F.R. § 164.508.

AUTHORIZATION

I hereby authorize ① _____ to furnish to AMA Insurance Agency, Inc. (“AMAIAI”) and Hartford Life Insurance Company medical records and information pertaining to

② _____.

This authorization is limited to the following medical records and type of information:

③ _____.

USES

AMAIAI and Hartford Life Insurance Company may use the medical records and type of information authorized only for the following purposes:

To process a claim for benefits under the AMA-sponsored Hospital Income Plan.

DURATION

This authorization shall become effective immediately and shall remain in effect until ④ _____.

NOTICE

Information used or disclosed pursuant to this authorization may be subject to further disclosure by the recipient and no longer be protected by the federal health information privacy regulations. However, AMAIAI and Hartford Life Insurance Company intend to use the information disclosed pursuant to this authorization for their own internal purposes and will take precautions to maintain the confidentiality of the information in accordance with their privacy policies and the requirements of federal and state law.

MY RIGHTS

I acknowledge and understand that I may revoke this authorization at any time by notifying AMAIAI in writing of my revocation; provided that any revocation of this authorization shall not apply to the extent that AMAIAI, or another covered entity, has taken action in reliance upon this authorization prior to receiving notice of my written revocation.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

I have a right to receive a copy of this authorization.

SIGNATURE

Date: _____

Signature: _____

Print Insured Name: _____

Print Patient Name: _____

Certificate Number or Social Security Number: _____

If signed by other than insured, indicate relationship: _____

Instructions:

Please complete each item, sign, date and return the Authorization in the envelope provided.

In the blanks spaces indicated on the form, fill in the following information:

① the name of any medical provider or hospital that provided treatment you in association with this claim. If this claim is incurred within the pre-existing period (see your certificate of insurance for details), provide the name of any provider who treated the patient 12 months prior to the effective date (6 months in California).

② the dates of hospital confinement or out-patient surgery claimed.

③ hospital medical records and physician office records are the most common sources of medical information we may need to process a claim. Suggest you specify “any and all” unless there is a specific type of record that you do not want released to us.

④ specific date that this Authorization will expire. Suggest you specify a date that is a minimum of three months to one year from date Authorization is signed.

If this Authorization is not completed in its entirety, we may not be able to obtain medical information needed to process your claim.