

# Union Security Life Insurance Company of New York

Administrative Office

P.O. Box 977122, Miami, FL 33197-7122 • 1.877.438.7085

Attn: DFS Claims Department

## Authorization for Release of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) requires us to get your written permission to obtain specific health information about you. We are requesting this information in order to process the claim you are presenting to our company. Therefore, please complete in detail, sign, date, and return the following form to us. We cannot process your claim until we have this form returned to us.

### I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY

I hereby authorize the medical providers listed below to release the following information to Union Security Life Insurance Company of New York.

INSURED INFORMATION			
NAME	SOCIAL SECURITY NUMBER	BIRTH DATE	DAYTIME TELEPHONE NUMBER
	- -	/ /	( )
STREET ADDRESS		CITY	STATE ZIP CODE
MEDICAL PROVIDER (doctor, hospital, etc.) WHO I AUTHORIZE TO RELEASE MY PERSONAL INFORMATION:			
NAME		TELEPHONE NUMBER	
		( )	
STREET ADDRESS		CITY	STATE ZIP CODE
DESCRIPTION OF INFORMATION TO BE RELEASED			
ENTIRE MEDICAL RECORD	HIV/AIDS TEST RESULTS OR DIAGNOSIS AND TREATMENT		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
OTHER			
I UNDERSTAND THAT:			
a. This Authorization may be revoked by me at any time by writing to the company and clearly stating that I wish to revoke this Authorization.			
b. 1. This Authorization will expire without any action by me one year after the date of my signing below. 2. This Authorization shall be valid for the duration of the claim (Arizona residents only).			
c. Revocation will not apply to my insurance company when the law provides my insurance company the right to contest a claim under my policy.			
d. This authorization is voluntary and I have the right to refuse to sign it.			
e. If I revoke this information, it will not apply to information that has already been released prior to my revocation.			
f. Information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.			
g. Information released by this authorization may be subject to redisclosure by the recipient and may not be protected any longer by the HIPAA Privacy Rule.			
h. I agree that a photocopy of this authorization shall be as valid as the original.			
i. I, or my authorized representative, have the right to receive a copy of this authorization.			
<b>WARNING:</b> *Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals, for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and substantial civil penalties.			
YOUR SIGNATURE (INSURED OR LEGAL REPRESENTATIVE)			DATE
X			/ /

AND if signing on behalf of a minor or as legal representative of another:

NAME OF PERSON YOU ARE SIGNING FOR (PROOF OF YOUR AUTHORIZATION MAY BE REQUIRED)

**ONE FORM MUST BE COMPLETED FOR EACH MEDICAL PROVIDER**  
Please photocopy this form if you need additional copies.