

**AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION
NEEDED TO ASSIST IN THE DETERMINATION OF ELIGIBILITY AND THE STATUS OF A
CLAIM FILED AGAINST THE STUDENT MEDICAL INSURANCE POLICY**

I hereby authorize Combined Life Insurance Company of New York and its agent, The Allen J. Flood Companies, Inc. to use and *disclose* **Protected Health Information** to the individual(s) indicated below, for the *express* and *limited* purpose to assist in the processing of my claim.

Information to be Used or Disclosed May Include: (Check All That Apply)

- | | |
|--|---|
| <input type="checkbox"/> Provider name, address & specialty (required) | <input type="checkbox"/> Medical diagnosis (optional) |
| <input type="checkbox"/> Dates of service (required) | <input type="checkbox"/> Services rendered (optional) |
| <input type="checkbox"/> Cost of services (required) | <input type="checkbox"/> Medications (optional) |

Persons or Class of Persons to Whom the Disclosure May be Made: (Check All That Apply)

- Student Health Service Staff
 Student Affairs Staff
 College/University Insurance Representative
 A Specific Individual, as follows: _____

I understand that this Authorization relates to individually identifiable health information about 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 health plan, health care clearinghouse, or health care provider as defined in the *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 The Allen J. Flood Companies, Inc. *in writing*. However, if I choose to do so, my revocation will not affect any actions taken *prior* to my revocation; and, that I may refuse to sign this authorization and that my refusal to sign will not be used as the sole basis for adversely affecting my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Insured Student's Name: (print) _____

ID or Social Security Number: ____-____-____ **Date of Birth:** ____/____/____

Claimant is: Self Dependent

(If Dependent, print full name and indicate relationship to insured)

Patient's or Authorized Representative's Signature: _____

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

This authorization will expire one year from the date it has been signed.