AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

SECTION A;

I, _____ (please print name legibly) hereby authorize the use and disclosure of Protected Health Information[1] about me as described in Section B below. I hereby give my express authorization to the following entities/providers to disclose my Protected Health Information in the manner as described in Section B: _____

_____

_____

_____

SECTION B:

- **Protected Health Information to be Used and Disclosed**
  The Protected Health Information that I authorize to be used and disclosed is as follows:
  - ☐ All Protected Health Information that you maintain on me from to PRESENT.
  - ☐ All Protected Health Information related to the following condition/injury/date of service:

    _____
  - ☐ Other (specify): _____

- **Persons/Entities Authorized to Receive and Use My Protected Health Information**
  I authorize the following persons or entities to receive and use the Protected Health Information that is described above:
  - ☐ Federated Health Claims Department personnel
  - ☐ Federated Health Underwriting Department personnel
  - ☐ Federated Health Administration Department personnel
  - ☐ Other (specify): _____

I understand that if my Protected Health Information is released to someone who is not required to comply with the Privacy Rule, such information may be re-disclosed and would no longer be protected by the Privacy Rule.

- **Purpose for the Disclosure**
  This disclosure is being made for the following reason(s):
  - ☐ Determining claims payment
  - ☐ Determining eligibility status
  - ☐ Other (specify): _____

- **Expiration**
  This Authorization will expire no later than one year after the date I have signed this Authorization.

(continued on back)

[1] Protected Health Information is information (i) about my physical or mental health or condition, health care or the payment of the health care; (ii) that identifies me directly or indirectly (ie there is reasonable basis to believe that the information could be used to identify me); and (iii) that it is maintained or transmitted by the provider or other covered entity.

SECTION C: Information About My Rights

I understand that I have the right to refuse to sign this Authorization, and that Federated Insurance will not condition the provision of payment or eligibility for coverage on the signing of this Authorization. However, if the purpose of this Authorization is for eligibility or enrollment determinations relating to me, or for Federated's pre-enrollment underwriting or risk rating determinations, my refusal to sign this Authorization will prevent me from enrollment and coverage.

I understand that I have the right to revoke my Authorization prior to the expiration date identified above. I can revoke it by notifying Federated's Privacy Official in writing, at 121 E. Park Square, Owatonna, MN 55060. No revocation will have any effect on actions already taken in reliance on the Authorization. No revocation will have any effect if this Authorization was obtained as a condition of obtaining insurance coverage and other law gives Federated the right to contest a claim or the coverage itself.

I understand that I have a right to retain a copy of this Authorization for my personal records.

SECTION D: Signature

By my signature, (i) I certify that I have read this Authorization; and (ii) that I agree to the release of my Protected Health Information in the manner described in this Authorization. I understand a copy or facsimile of this document is to be accepted as the original.

Printed Name

Date of Birth

Signature

Date

Name of personal representative, if applicable

Relationship of personal representative to member