Authorization for Disclosure of Personal Information

(Required by HIPAA and State Laws)

Insured Name: Coverage ID:
Date of Birth: Last 4 of SSN:

1. I authorize all hospitals, medical care facilities and clinics, physicians, dentists, other medical or dental practitioners, pharmacies, pharmacists, pharmacy benefit managers, insurance companies, third party administrators, health plans, health maintenance organizations, employers, medical examiners, coroners and other law enforcement officials to disclose Personal Information about the insured to [Mutual of Omaha]. The providers authorized to release information include, but are not limited to:

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2. Personal Information includes but is not limited to an entire medical record and any other health information concerning the insured (excluding psychotherapy notes), insurance policies and claims, including those containing diagnoses, care or treatments, prescription drug information, alcohol or drug abuse treatment information, or information regarding communicable or infectious conditions, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS, AIDS Related Complex, admission records, emergency room records, outpatient records, referrals, consults, lab results, office notes, autopsy results, incident and toxicology reports, finances, and occupation.

3. This Personal Information will be used by [Mutual of Omaha] to evaluate a claim(s) for benefits.

4. This authorization is valid until revoked, or 24 months from the date signed, whichever comes first.

5. I may revoke this authorization at any time by written notice to [Mutual of Omaha] however revocation will not affect any disclosure of Personal Information that occurred prior to the receipt of my revocation or any action [Mutual of Omaha] has taken action in reliance on the authorization.

6. I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my eligibility for benefits cannot be considered, however my enrollment in the insurance plan will not be affected.

7. I further understand that I have a right to obtain or retain a copy of this authorization and a copy is as valid as the original. I may obtain a copy of this authorization or revoke this authorization by sending written notice to [Mutual of Omaha], 3300 Mutual of Omaha Plaza, Omaha NE 68175.

8. I understand that if the person/organization authorized to receive the use of the Personal Information is not a health plan or health care provider covered by federal and state privacy regulations, the Personal Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by these privacy regulations.

_____	_____
Signature of Insured/Legal Representative	Date
_____	_____
Printed Name of Insured/Legal Representative	Type of Legal Representative (Legal Documentation Required)