AUTHORIZATION FOR USE OF HEALTH-RELATED INFORMATION
(This authorization complies with HIPAA Privacy Rules.)

Name of Policyholder:	Policy Number:
Address Line 1:	Address Line 2:
City, ST, Zip:	Date of Birth: _____/ _____/ _____

NOTE: If this form is completed by a Legal Representative then a valid Power of Attorney, Guardianship, Conservatorship or similar documentation must accompany this form.

Use of Health Related Information *to* Senior Health Insurance Company of Pennsylvania

I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically-related facility, pharmacy, pharmacy benefits manager, federal, state or local government agency, insurance or reinsuring company, third-party claims administrator, consumer reporting agency, employer, Medical Information Bureau (MIB) or any other organizations, institutions or persons with knowledge or records of me and my health, including but not limited to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to **Senior Health Insurance Company of Pennsylvania** ("the Company"), or its legal representative. I understand that information obtained by use of this authorization, including individually identifiable health information, may be used for the purpose of administering my insurance benefits and/or making eligibility, risk or claim determinations, and that this information may be transferred to any organization or person employed by or representing the Company to assist with this purpose. I understand that information disclosed under this authorization may include medical records and reports concerning my physical or mental health and any and all associated diagnoses, prognoses, care or treatments, diagnostic and laboratory tests, prescription drug information and history, and information regarding drug use, alcoholism, mental illness, sexually transmitted diseases, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company or their authorized administrator and may no longer be protected by the same rule that applied in the first instance. This authorization is valid while my claim is pending, while it remains active or in order for the Company to process my appeal or administer benefits. Except in the case of an appeal, this authorization shall expire on the date my claim ends or seven years from the date of my signature below, whichever is later. I understand that my authorized representative or I have the right to request and receive a copy of this authorization. A photocopy of this authorization shall be as valid as the original.

I understand that my authorization is voluntary and that I can refuse to sign this authorization. I do understand, however, that failure to sign this authorization may impair the Company's ability to evaluate my claim and may be a basis for denying a claim for benefits. I further understand that I have the right to revoke this authorization by notifying the Company in writing at **Senior Health Insurance Company of Pennsylvania** *, Attn: Claim Review,* ***P. O. Box 64913, MN 55164****.* Such revocation may be the basis for denying benefits.

IMPORTANT: Policyholder (or Legal Representative) Signature: X_____

Date: _____

Type of authority to act on behalf of the insured (please check box, if applicable):

☐ Legal Representative ☐ Power of Attorney ☐ Guardianship ☐ Conservatorship

AUTHORIZATION FOR DISCLOSURE OF HEALTH-RELATED INFORMATION

(This authorization complies with HIPAA Privacy Rules.)

Name of Policyholder:	**Policy Number:**
Address Line 1:	**Address Line 2:**
City, ST, Zip:	**Date of Birth: ____/ _____/ _____**

NOTE: If this form is being completed by a Legal Representative then a valid Power of Attorney, Guardianship, Conservatorship, or similar documentation must accompany this form.

Health Information to be Disclosed *by* Senior Health Insurance Company of Pennsylvania I authorize the Company to disclose my Protected Health Information to the following

(Person/Organization Receiving Information): _____

_____

The Relationship of this person/organization to me is: _____

This recipient may use the health information authorized on this form for the following purpose(s):

_____

_____

This authorization shall be effective as of the date of my signature below. I understand that I can revoke this authorization at any time, except to the extent it has already been relied upon, by giving written notice to: **Senior Health Insurance Company of Pennsylvania**, *Attn: Claim Review,* ***P. O. Box 64913, MN 55164***. I understand that the Company may not deny me benefits due to refusal to sign this authorization. I further understand that my signature on this form does not authorize any changes to my policy information or to my policy or change the way the Company communicates with me. I also understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. The undersigned is entitled to receive a copy of this form. A photocopy of this authorization shall be as valid as the original.

Policyholder (or Legal Representative)

Signature: X _____ Date: _____

Type of authority to act or sign on behalf of the policyholder (please check box, if applicable):

☐ Legal Representative ☐ Power of Attorney ☐ Guardianship ☐ Conservatorship

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