

# Authorization to Disclose Protected Health Information



**Notice: All information requested must be provided or will result in an invalid authorization.**

Name of Individual Whose Information Will Be Disclosed	Individual's Date of Birth
	/ /
Individual's Social Security Number	Policy/Certificate Number

I \_\_\_\_\_, authorize American Community Mutual Insurance Company to disclose the following Protected Health Information of the above-named individuals:

- All health information
- Other \_\_\_\_\_

to be used by or disclosed to the following person(s): \_\_\_\_\_  
(person/entity who will receive information, i.e. spouse, parent, sibling, attorney, agent, medical provider)

for the following purpose:

- At my request
- Other \_\_\_\_\_

This authorization is valid from the date signed until:

- My policy terminates
- Other \_\_\_\_\_

1. This authorization includes **confidential communicable disease related information, confidential HIV-related information, and** information about drug and alcohol use. This authorization does not provide for release of psychotherapy notes.
2. This authorization is valid for 30 months (24 months in Arkansas, Iowa, Missouri, Oklahoma, South Carolina and Texas) from the date signed. A photographic copy of this authorization shall be as valid as the original. I know that I, or my authorized representative, may request and are entitled to receive a copy of this authorization. This authorization permits disclosure of protected health information for 10 years prior to the date signed.
3. I acknowledge that, upon request, I or my representative are entitled to receive a copy of this authorization and a copy of American Community's Notice of Your Privacy Rights which describes how my protected health information may be used or disclosed.
4. I understand that I have the right to request that American Community restrict uses or discloses of my protected health information; that American Community is not required to agree to the request; and that American Community is bound by the restrictions to which it agrees.
5. **There are state specific laws regarding specific health conditions for which we cannot use this form to obtain health information about you. We will ask you to sign a state specific authorization form if necessary.**
6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under number 7 of this form.
7. If the purpose of the authorization is for American Community to determine eligibility before enrollment, the requested use or disclosure is not for psychotherapy notes, and I refuse to sign this authorization, American Community reserves the right to deny enrollment or eligibility for benefits.
8. I have the right to revoke this authorization by notifying American Community in writing, except to the extent that American Community has taken action in reliance on my authorization.

9. I understand that the information I authorize American Community to receive may be re-disclosed and no longer protected by federal privacy regulations. **However, confidential communicable disease related information and confidential HIV-related information will not be re-disclosed without specific authorization as required by state law.**

\_\_\_\_\_  
Signature of individual, parent or personal representative\*

\_\_\_\_\_  
Printed name of individual, parent or personal representative

\_\_\_\_\_  
Relationship to individual

\_\_\_\_\_  
Date

\*If you are the individual's representative and are not the parent of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

**PLEASE RETAIN A COPY FOR YOUR RECORDS**

## NOTICE OF YOUR PRIVACY RIGHTS

We know that your trust in us is very important. We are committed to protecting your privacy rights. Please read this document carefully. It discloses your privacy rights.

**Obtaining Information About You** - We may obtain information from your application, a telephone interview with you, claims history with us, policies you have or had with us, account balances and premium payment history, and other sources, such as health care providers (medical information), and consumer reporting agencies (credit reports). Your address, birthday, telephone number, social security number are examples of such information. You may have to share such information with us, our affiliates, agencies or others working with us.

**Our Use of Personal Information** - We will share such information only with companies associated with us. We, or your agent or broker may use your information to offer you products or help you choose a product.

We may, as permitted by the law and without your prior approval, give information about you to persons who do business for us, your agent or broker, other insurance companies, or other persons handling your business, insurance company support organizations, regulatory or law enforcement authorities; and our affiliated companies. Information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

### Your Rights

- The right to access, inspect and copy the personal information pertaining to you that we maintain in our files about you.
- The right to request that we correct or amend any personal information that we have about you.

To exercise these rights, please send a written request to the attention of the Privacy Coordinator.

**How We Protect Your Personal Information** - We protect the information we share with companies working for us through an agreement. The agreement obligates those companies to keep your information confidential.

Only our employees who work to service your business see your personal information. We have trained our employees to closely follow our privacy rules for your protection. Your privacy rights will continue if you cease to be our customer.

**THE REMAINDER OF THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We are required to maintain the privacy of your personal medical information and provide you with this notice as to our legal duties and privacy practices. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make any new provisions effective to all of the medical information that we maintain about you. If we revise this notice, we will provide you with a revised notice by mailing the revised notice to the address you have supplied us.

### STATEMENT OF YOUR RIGHTS

You have the right to know how we use or disclose your personal medical information. There are certain uses and disclosures of your personal medical information that we are permitted or required to make by law without your permission. In addition, you have:

- The right to request that we place additional restrictions on our uses and disclosures of your personal medical information, but we are not obligated to agree to any such restrictions.
- The right to access, inspect and copy the protected information pertaining to you that we maintain in our files, and the right to request that we correct or amend any personal medical information that we have about you.
- The right to receive an accounting of the disclosures of your personal medical information that we make for purposes other than activities related to your treatment, or our payment functions or other health care operations.
- The right to request that you receive communications of personal medical information in a confidential manner.
- The right to obtain a paper copy of this notice from us on request.

To exercise these rights please send a written request to the attention of the Privacy Coordinator.

### PERMISSIBLE USES AND DISCLOSURES OF PROTECTED MEDICAL INFORMATION

**Payment Functions.** We may use or disclose your protected medical information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing. For example, payment functions may include (but are not limited to) reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.

**Health Care Operations.** We may also use or disclose your protected medical information without your permission to carry out certain insurance-related activities. For example, these activities include using your protected information for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of another contract of health

insurance, placing a contract for reinsurance of risk relating to claims for health care, and performing audit functions to ensure compliance and proper claims payment.

**Group Health Plan.** We may disclose your protected medical information to your employer as necessary for the purpose of reporting claims experience or conducting an audit if you are covered under an employer-based group health insurance plan.

**Business Associates.** We may disclose your protected medical information to our business associates. There are some services provided in our company through contracts with our business associates.

**Uses Permitted By Law.** We may also use or disclose your protected medical information without your written permission for purposes permitted or required by law.

**Authorized Uses.** All other disclosures of your protected medical information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.

**COMPLAINTS ABOUT MISUSE OF INFORMATION** - If you believe your privacy rights have been violated you may complain either directly to us or to the Secretary of Health and Human Services (H.H.S.). Please submit all complaints in writing to us or H.H.S. as follows:

American Community Mutual Insurance Company

Attn: Privacy Officer  
39201 Seven Mile Road  
Livonia, MI 48152

U.S. Department of Health and Human Services (H.H.S.)

Attn: Secretary  
200 Independence Ave. S.W.  
Washington, DC 20201

You will not be retaliated against in any way for filing a complaint.

**OBTAINING FURTHER INFORMATION** - Please call American Community at (800) 991-2642 if you have any questions or comments.

Effective: December 1, 2007