AMERICAN FIDELITY
a different opinion

American Fidelity Assurance Company | Mail to: Worksite Group Benefits Department
P.O. Box 25160 | Oklahoma City, Oklahoma | 73125-0160
Toll Free Phone 1-800-662-1113
Toll Free Fax 1-800-818-3453
americanfidelity.com

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

AF Account# _____ Printed Name of Patient _____ Patient's Date of Birth _____

1. I authorize the use and disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

American Fidelity Assurance Company
P.O. Box 25160 Oklahoma City, OK 73125

For the purpose of: _____

3. The type and amount of information to be used or disclosed is as follows, but does not include psychotherapy notes:

_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization (individual or organization requesting records):

_____

_____

_____

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must present my revocation to the above individual or organization. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. In any event, this authorization will be valid for a period of time no longer than the duration of any claim or twenty-four months, whichever time period is shorter. A photocopy of this authorization shall be as valid as the original.

7. I understand that authorizing this disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure payment of claims, enrollment or eligibility for benefits. I understand I may receive a copy of this authorization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules. If I have questions about disclosure of my health information, I can contact American Fidelity Assurance Company, Attention: Privacy Official, P.O. Box 25523, Oklahoma City, Oklahoma 73125, or by calling 1-866-55-HIPAA, or by contacting the company at hipaa@americanfidelity.com.

_____ _____
Signature (Patient) or Personal Representative (if applicable) Date Signed

_____
Relationship of Personal Representative to Patient (if applicable)
If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.

Please retain a copy for your personal records, or you may request a copy from our Company.