AMERICAN FIDELITY
a different opinion

Benefits Department | P.O. Box 25160 | Oklahoma City, Oklahoma 73125-0160
American Fidelity Assurance Company | 800-662-1113 | Fax: 800-818-3453 | **americanfidelity.com**

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Account# | Patient's Full Name | Patient's Date of Birth

1. I authorize American Fidelity to disclose the health information of the above named individual for the purpose of:

_____

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

_____

(If nothing is specified above, we will apply this authorization to all information in our possession.)

3. 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 (except for psychotherapy notes), and treatment for alcohol and drug abuse.

4. This information may be disclosed to and used by the following individual(s) or organization(s):

_____

_____

5. 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 American Fidelity. I understand the revocation will not apply to information already released in reliance on this authorization. I understand that revocation will not apply to my insurance company when the law gives my insurer 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 no longer than the duration of any claim or 24 months, whichever time period is shorter. A photocopy of this authorization shall be as valid as the original.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. Signing this form is not required 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 includes 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 the company by mailing American Fidelity, Attention: Privacy Official, P.O. Box 25523, Oklahoma City, OK 73125, calling 866-55-HIPAA, or emailing 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 and documentary support (example: power of attorney) must be included.

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