Standard Authorization to Use or Disclose Protected Health Information (PHI)

I: Individual (Name and information of person whose protected health information is being disclosed)

Name ______ **Group #** ______ **Identification\Subscriber #** ______

Social Security Number ______ **Date of Birth** ______

Address ______ **City** ______ **State** ______ **ZIP** ______

Area Code & Telephone Number ______ **E-mail Address (if available)** ______

II: Authorization and Purpose:
I request and authorize Dearborn National Life Insurance Company to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive your information ______ **Relationship** ______ **Purpose** ______

Address ______ **City** ______ **State** ______ **Zip** ______

III: Specific Description of Information to be Used or Disclosed

Release of Protected Health Information (check one or more)

			Dates of Services From:	To:
☐	Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).	______	______
☐	Claims:	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions, claim payment or denial reasons, etc).	______	______
☐	Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.	______	______
☐	Premium:	Includes information related to billing cycles, bank draft changes, etc.	______	______
☐	Services from (provider or supplier):	Provider name: ______ (Includes information related to services rendered by a specific provider or supplier)	______	______
☐	Other:	______ (Specify other information that is not listed in one of the categories above.)	______	______

Dearborn Group™

IV: Expiration and Revocation:

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed ☐ Other (insert date or event): ______________________

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

V: Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

______________________________ ______________________________
Signature **Date: month/day/year**

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of these documents if they are already on file with Dearborn National Life Insurance Company:

______________________________ ______________________________
Personal Representative's Name **Relationship to Individual**

______________________________ ______________________ ________ ________
Personal Representative's Address **City** **State** **ZIP**

______________________________ ______________________________
Personal Representative's Area Code & Telephone Number **Personal Representative's E-mail address (if available)**

BEFORE RETURNING YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:

(1) MAKING A PHOTOCOY OF THIS SIGNED AUTHORIZATION; OR
(2) COMPLETING AND SIGNING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

Mail your completed signed authorization to:
Privacy Coordinator
Dearborn Life Insurance Company
Administrative Office:
701 E. 22nd St Ste 300
Lombard, IL 60148
Or fax to:
Fax: 1-630-495-0575

If you need assistance completing the form, please contact the Customer Service number listed on the back of your Member Identification Card.