ADMINISTRATIVE CONCEPTS, INC.

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION NEEDED TO ASSIST IN THE DETERMINATION OF THE STATUS OF A CLAIM FILED AGAINST THE MEDICAL INSURANCE POLICY

I hereby authorize Administrative Concepts, Inc. to obtain and *disclose* **Protected Health Information** and disclose such information to the individual(s) indicated below, for the *express* and *limited* purpose to assist in the processing of my claim.

Information to be Used or Disclosed May Include:

[ ] Provider name, address & specialty (required)
[ ] Dates of service (required)
[ ] Cost of services (required)
[ ] Medical diagnosis (optional)
[ ] Services rendered (optional)
[ ] Medications (optional)

Persons or Class of Persons to Whom the Disclosure May be Made:

[ ] Student Health Service Staff
[ ] Employer
[ ] A Specific Individual, as follows: _____
[ ] Student Affairs Staff
[ ] Association Representative

I understand that individually identifiable health information relating to me, which is called *Protected Health Information* as defined by the *Privacy Rule* of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA);* and,

that if the person or entity that receives this information is not a health plan, health care clearinghouse, or health care provider as defined in the regulation text of the *Privacy Rule*, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law; and,

that I may revoke the authorization at any time by notifying Administrative Concepts, Inc. *in writing*. However, if I choose to do so, my revocation will not affect any actions taken by Administrative Concepts, Inc. *prior* to my revocation; and,

that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires 365 days after signing, or the date Administrative Concepts, Inc. responds to my request for claims status, whichever is earlier.

Insured Member's Name: (print) _____

Member ID Number _____ **Date of Birth:** ____/____/____

Claimant is: [ ] Self **[ ] Dependent (print full name and indicate relationship to insured)**

_____

Patient's or Authorized Representative's Signature: _____

Date: ____/____/____ **If Authorized Representative, Relationship to Patient:** _____