Seven Corners Form
Authorization of Use and Disclosure of Privacy and Claims Information

Completion and submission of this form authorizes Seven Corners, Inc. to use and disclose the information indicated below.

Name of Insured:			
Certificate #:		**Date of Birth:**	
Name of Insured's Guardian or Legal Representative:			
☐ **All information may be used or disclosed** ☐ **Only information indicated may be used or disclosed ➔**			
Disclose personal health information indicated above to:	**Person/Organization:**		
	Address:		
	Relationship:		
Expiration date of this authorization*:			

**This authorization is effective upon receipt by Seven Corners. If no expiration date is provided this authorization will expire 12 months after the signature date below.*

Risk of Re-disclosure:

The person or organization indicated above may provide information disclosed under this authorization to others. The privacy of this information may not be protected under the applicable privacy regulations in such situations. Seven Corners does not assume responsibility for the use of this information by said person or organization.

Approval Signature

Your signature below affirms that you agree to the above terms of disclosure for the specified personal health information. Retain a copy of this document for your records.

Insured (Guardian/Legal Representative) Signature	**Date**

Return the completed and signed form to Seven Corners:

Mail:
Seven Corners, Attn: Claims Dept.
303 Congressional Boulevard
Carmel, IN 46032 USA

Email:
Claims@sevencorners.com

Fax
1-317-575-2256

Right to Terminate or Revoke Authorization:

You may revoke or terminate this authorization by submitting a written revocation (Attn: Privacy Officer) to Seven Corners, Inc. using the contact information above.