Reset

Authorization for the Use or Disclosure of Protected Health Information

Pekin Life Insurance Company
2505 Court Street
Pekin, IL 61558

As required by the Health Insurance Portability and Accountability Act of 1996, Pekin Life Insurance Company may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

Patient Name:_____ **Member ID:**_____

Date of Birth:_____

AUTHORIZATION SECTION

I hereby authorize the use and disclosure of the following health information that pertains to the patient listed above:

_____

_____

for the following purpose:

_____

_____

I authorize the following person(s) to make these disclosures of my health information:

_____

I authorize the following person(s) to receive these disclosures of my health information:

_____

Address:_____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the Privacy Officer at Pekin Life Insurance Company at

the address listed above. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire _____ *(print expiration date or expiration event, such as upon termination of coverage.)* If I do not specify an expiration date, event or condition, this authorization will expire in one year.

I understand that I am under no obligation to sign this authorization.
I understand that Pekin Life Insurance Company may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

Signature: _____ Date: _____

Print Name:_____ Telephone: _____

If not signed by the patient, please indicate:
Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient
- ☐ other (specify) _____

REVOCATION SECTION

I hereby revoke this authorization.

_____ _____
Signature Date

