

First **Catholic** Slovak
Ladies **Association**
24950 Chagrin Blvd, Beachwood, OH 44122-5634 800-464-4642

HIPAA Authorization

This Authorization permits your physician, doctor, or health care provider to disclose protected health information (“PHI”) to First Catholic Slovak Ladies Association of the United States of America (“FCSLA”) for processing your life insurance application.

I. Information About the Use or Disclosure of Individually Identifiable Health Information

I, _____ (Print Name) hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that individually identifiable health information: (A) either identifies or reasonably may be used to identify the individual who is the subject of the information; and (B) includes information regarding his or her physical or mental condition and/or payment for health care. I have read this Authorization in its entirety, including the Section labeled “Important Information About My Rights,” and hereby authorize and consent to the use or disclosure of my individually identifiable health information as described below.

_____ (Name of Disclosing Party) is authorized to disclose the information described below.

Specific and meaningful description of information to be used or disclosed:

I authorize disclosure of the information to FCSLA for the purpose of processing my life insurance application. A photocopy of this document is valid as an original.

This Authorization will expire one year after the date of execution below.

II. Important Information About My Rights

- This Authorization is voluntary and I may revoke this Authorization at any time by submitting a written revocation to _____ (Name and Address of Disclosing Party). The revocation will not have any effect on any actions taken before receipt of the revocation, as may be described in the health plan’s notice of privacy practices.
- I may request to see and copy the information described in this Authorization.
- I am entitled to a signed copy of this Authorization.
- Treatment will not be conditioned upon my signing this Authorization and the execution of this Authorization is completely voluntary.
- The information that is used or disclosed pursuant to this Authorization may be redisclosed by FCSLA. Upon disclosure to FCSLA, the information will no longer be subject to the privacy regulations under the Health Insurance Portability and Accountability Act or State law.

III. Signature of Participant or Participant’s Personal Representative

Signature of patient/applicant _____
Date

Printed name of the patient/applicant’s personal representative
(if applicable): _____

Relationship to the patient/applicant, including authority for status as representative (if applicable): _____

****Please complete the following sections in their entirety. This information will be used to obtain medical records that pertain to your application for Life Insurance. The HIPAA Authorization Form on the reverse side must also be completed.**

Primary Care Physician:

Name: First _____ Last _____

Street Address _____

City _____ State _____ Zip Code _____

Phone # _____

Specialist:

Name: First _____ Last _____

Street Address _____

City _____ State _____ Zip Code _____

Phone # _____

Comments: