Revision date: 02/2018

# HIPAA Disclosure Authorization Form

I, _____, hereby authorize SET SEG to disclose my
Full Name

protected health information to _____ for the purpose of
Recipient

(check all that apply):

- ☐ Eligibility determinations
- ☐ Claims issues
- ☐ Changing contact information
- ☐ Correcting personal information
- ☐ Requesting ID cards
- ☐ Life-changing events
- ☐ Coordination of benefit issues
- ☐ Prescription drug information
- ☐ All of the above

By signing below, I understand the following regarding the health information authorized to be released by this form:

- I can make copies of my health information.
- I can review my health information.
- At any time, I can revoke my permission to give the person listed continued access to my health information by sending SET SEG a written revocation.
- A written revocation will only apply to future disclosures and not to information that has already been released.
- Information that is disclosed as a result of this authorization form could be made public by the recipient of the information.
- Federal or state law may not provide you protection or recourse if information is made public under these circumstances.

_____ _____
Date Signature of individual or representative

_____
Authority or relationship to individual, if representative

Expiration date: This authorization will expire on _____.
Date

If no date is listed, the expiration date will be six years from the date of this authorization.

SET SEG
School Insurance Specialists