Student Resources (SPC), Ltd

For use only with policies underwritten by Student Resources (SPC) Ltd.

7-1-2013

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Purpose: This form is used to confirm the direction of an individual that our Company use or disclose health information for a particular purpose. **PLEASE RETAIN A COPY FOR YOUR RECORDS**.

SECTION A: Information about the Individual granting the authorization.

I authorize the use and/or disclosure of my health information as described in Section B below. I understand this authorization is voluntary and made to confirm my direction.

I understand that the persons or organizations I authorize below to receive and/or use the health information described below are not bound by this authorization and may further disclose the health information.

Name: ______________________________

Address: ______________________________

Telephone: ______________________ E-mail: ______________________

ID or Policy No.: ______________________ Other Identification Number: ______________

SECTION B: Information being authorized for use or disclosure.

Health Information to Be Used and/or Disclosed: Specifically and meaningfully describe the health information you are authorizing to be used and/or disclosed:

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SECTION C: Entities Authorized **to Receive and Use**: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing our Company to disclose and/or let use the health information described above:

______________________ ______________________

______________________ ______________________

______________________ ______________________

SECTION D: Expiration and Revocation.

Expiration: This authorization will expire (complete one):

☐ On ____/____/_________ (Specific Date)

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

____

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Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: UnitedHealthcare StudentResources

Telephone: 1-800-767-0700 or 1-469-229-6700 **Fax**: 1-469-229-5532

Address: P.O. Box 809025, Dallas, TX 75380-9025

SIGNATURE OF INDIVIDUAL OR INDIVIDUAL'S PERSONAL REPRESENTATIVE.

I, ____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the Company. I understand that, by signing this form, I am confirming my authorization that the Company may use and/or disclose to the persons and/or organizations named in this form the health information described in this form.

Signature: ______________________________________ Date: ____________________________

If this authorization is signed by a personal representative on behalf of the individual, please attach the documentation of personal representative designation and complete the following:

Personal Representative's Name: ____

Relationship to Individual: ____

IMPORTANT:

THIS AUTHORIZATION WILL NOT BE ACCEPTED AND IS NOT VALID UNLESS EACH SECTION IS COMPLETED.

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.