

Authorization to disclose protected health information

IMPORTANT: We cannot process your application without this completed form.

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of healthcare services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Health Advantage and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any healthcare item or service in relation to the healthcare provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Health Advantage in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Health Advantage may disclose this information to others as required or permitted by law and as set out in the Health Advantage Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Health Advantage, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

This authorization includes authorization to release information on the diagnosis and treatment of mental illness, alcohol, and drug use, as well as authorization to release information on the diagnosis, treatment, and testing results related to HIV-AIDS, and sexually transmitted diseases, unless otherwise restricted by applicable law.

Please note the following consequences if you decline to sign this authorization for release of your medical information, or if you later revoke it: in that event, we may be unable to process your application or evaluate a claim for coverage and would then deny your application of your claim for policy benefits.

Applicants age 18 and older

This authorization must be signed by each applicant age 18 or older

Print name(s) of applicants	Signature	Date (mm/dd/yyyy)

Applicants under age 18

Print name(s) of applicants	Parent/Legal Guardian's Signature (if policy for a minor)	Date (mm/dd/yyyy)