

Overland Park Office
Corporate Headquarters
7400 College Blvd., Suite 100
Overland Park, KS 66210
800-955-1991



Salt Lake City Office
NACDA Insurance Division
2180 South 1300 East, Suite 520
Salt Lake City, UT 84106
800-955-1991, Ext. 198

HIPAA Authorization for Use and Disclosure of Information

I hereby authorize the use and/or disclosure of my individually identifiable health information (the "Information") as follows:

In connection with the insurance claim on the accompanying Proof of Loss Form dated _____ (the "Claim"), I authorize my health care providers to disclose to Summit America Insurance Services, LC, my sponsoring college or university, my named parent(s) or guardian(s) and/or any insurance companies to whom the Claim may be submitted (a "Payor"), all Information related to the Claim, for the specific purposes of facilitating the processing and/or payment of the Claim by Summit America Insurance Services, LC and communicating with Summit America Insurance Services, LC and the Payor about the Claim.

This authorization is specifically limited to the individually identifiable health information related to the Claim.

I further understand and agree:

1. This authorization will expire upon the termination of the insurance policy between my sponsoring college or university and the Payor.
2. I may revoke this authorization at any time by notifying Summit America Insurance Services, LC in writing (although the revocation will not have any effect on any actions taken before receiving the revocation).
3. I may see and copy the information described on this form if I ask for it.
4. I am not required to sign this form in order to receive health care services from my provider.
5. The information that is used or disclosed under this authorization may be re-disclosed by the receiving entities, but only for the specific purposes authorized.

Parent(s)/Guardian(s) Name(s): _____

If I am signing this Authorization as a Claimant's Representative, I certify that I have the authority to act on behalf of the Claimant and that the information provided below to verify my identity is correct.

Signature of Claimant or Claimant's Representative

Date

Name of Claimant's Representative, if applicable: _____

Representative's DOB: _____ Relationship to the Claimant _____