

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

This Authorization is made pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations (45 C.F.R. Parts 160 and 164).

1. Insured's Information

Name of Insured Person: _____

Date of Birth: _____

Address: _____

Certificate Number (s): _____

2. Person or Entity Authorized to Disclose PHI

I authorize AMA Insurance Agency, Inc., 330 N. Wabash Avenue, Suite 39300, Chicago, IL 60611-5885, to disclose PHI as outlined in this Authorization and to accept a photocopy and/or electronic copy of this authorization as if it were an original.

3. Person or Entity Authorized to Receive PHI

I authorize disclosure of my Protected Health Information to:

Name: _____

Address: _____

Email: _____

4. Description of Information to Be Disclosed

The following Protected Health Information (PHI) may be disclosed (check all that apply):

Medical records (including history and physicals)

Billing and payment records

Claims records

Other (specify): _____

Date range of information: From _____ To _____

5. Purpose of Disclosure

The purpose of this disclosure is (check one):

At my request

Care coordination or case management

Other (specify): _____

6. Sensitive Information and 42 C.F.R. Part 2

I understand that my health records may include information related to mental health, substance use disorder treatment, HIV/AIDS, genetic testing, or other sensitive conditions.

7. Expiration of Authorization

This Authorization will expire on (check one):

- A specific date: _____
- Upon the occurrence of the following event: _____
- One (1) year from the date of my signature

8. Right to Revoke

I understand that I may revoke this Authorization at any time by providing written notice to the insurance company listed above, except to the extent that action has already been taken in reliance on this Authorization.

9. Redisclosure Notice

I understand that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA, except where prohibited by law.

10. No Conditioning

I understand that signing this Authorization is voluntary and that my treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this Authorization, except as permitted by law.

11. Signature

I certify that I have read and understand this Authorization, and I authorize the disclosure of my Protected Health Information as described above.

Signature of Insured or Personal Representative: _____

Printed Name: _____

Date: _____

If signed by a personal representative, describe authority to act on behalf of the insured (e.g., parent, legal guardian, power of attorney) and attach authorizing documents:
