

Professional Insurance Company

PO Box 85656, Lincoln, NE 68501

Phone Number: 1-800-289-1122

Fax Number: (402) 479-8937

Authorization to Obtain and Disclose Protected Health Information and Other Information

Name: _____ **Claim #** _____ **Policy #** _____

I authorize the release and disclosure of my protected health information and other information as described below.

My **protected health information** is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider or health care facility to which this authorization is directed to disclose or furnish to Professional Insurance Company (PIC)* including any legal representative designated by PIC, the following protected health information: **Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents.** This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse treatment or services or mental health care to the extent permitted by law.

I further authorize any employer to which this authorization is directed to disclose or furnish my employment, financial and wage information to PIC and any legal representative that it might designate.

I authorize PIC to use or disclose this protected health care information, in connection with payment or health care operations, to any person or entity performing a business or legal function on behalf of PIC or as otherwise specifically permitted or required by law. I understand that information disclosed to, or by, PIC pursuant to this authorization might be subject to re-disclosure and no longer protected by the HIPAA Privacy Rule.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect the payment of claims; (3) I have the right to revoke this authorization at any time by writing to PIC at the address listed at the top of this form; and (4) I should sign both copies of the authorization provided, retaining one copy for my records.

This authorization is valid for up to 12 months from the date it was signed. Revocation of this authorization will not affect the rights of any person or entity who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

Date Authorization Signed

Signature of Claimant or Authorized Personal Representative
(e.g., parent or guardian, if minor)