HIPAA Consent Form for Disability Insurance Claims

I authorize the use or disclosure of my protected health information as described below. I understand that this authorization is voluntary.

Patient Information

Name: _____

Date of Birth: _____

Address: _____

Recipient Information

I authorize the following person(s) or organization(s) to disclose my health information:

Name/Organization: _____

Address: _____

Phone: _____

Purpose of Disclosure

The purpose of this disclosure is to process my disability insurance claim(s).

Description of Information to Be Disclosed

I authorize the release of all relevant health information, medical records, and related documents necessary for the assessment of my disability insurance claim.

Expiration

This authorization will expire one year from the date signed below or on this date: _____.

Right to Revoke

I understand I may revoke this authorization at any time by submitting a written request to the organization listed above, except to the extent that action has already been taken in reliance on this authorization.

Signature

_____ Signature of Individual

Date: _____

_____ If Individual is a Personal Representative, Print Name and Relationship

Date: _____

A copy of this authorization will be as valid as the original. You are entitled to a copy of this form after you sign it.