Standard Authorization to Use or Disclose Protected Health Information (PHI)

I: Individual (Name and information of person whose protected health information is being disclosed)

Name	Group #	Identification\Subscriber #

Social Security Number	Date of Birth

Address	City	State	ZIP

Area Code & Telephone Number	E-mail Address (if available)

II: Authorization and Purpose:
I request and authorize Dearborn National Life Insurance Company to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive your information	Relationship	Purpose	
Legal - Ease Digital Imaging LLC	Record Retrieval Company	Litigation	
Address	**City**	**State**	**Zip**
2496 Meadowcroft Dr	Burton	MI	48519

III: Specific Description of Information to be Used or Disclosed

Release of Protected Health Information (check one or more)

		Dates of Services From:	To:
☐ Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).		
☐ Claims:	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions, claim payment or denial reasons, etc).		
☐ Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.		
☐ Premium:	Includes information related to billing cycles, bank draft changes, etc.		
☐ Services from (provider or supplier):	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier)		
☐ Other:	_____ (Specify other information that is not listed in one of the categories above.)		

Dearborn Group™

IV: Expiration and Revocation:

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed ☐ Other (insert date or event): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

V: Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Signature _____ **Date: month/day/year** _____

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of these documents if they are already on file with Dearborn National Life Insurance Company:

Personal Representative's Name _____ **Relationship to Individual** _____

Personal Representative's Address _____ **City** _____ **State** _____ **ZIP** _____

Personal Representative's Area Code & Telephone Number _____ **Personal Representative's E-mail address (if available)** _____

BEFORE RETURNING YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:

(1) MAKING A PHOTOCOY OF THIS SIGNED AUTHORIZATION; OR
(2) COMPLETING AND SIGNING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

Mail your completed signed authorization to:
Privacy Coordinator
Dearborn Life Insurance Company
Administrative Office:
701 E. 22nd St Ste 300
Lombard, IL 60148
Or fax to:
Fax: 1-630-495-0575

If you need assistance completing the form, please contact the Customer Service number listed on the back of your Member Identification Card.