AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH/DENTAL INFORMATION TO A THIRD PARTY

1. Authorization. I authorize Companion Life Insurance Company to disclose my protected health/dental information to the following individual/entity in the manner described in Section 2 below.
(Must complete all fields in Section 1)

Name: _____

Address: _____

Telephone: _____ Relationship: _____

2. Scope of Authority. I authorize the disclosure of my protected health/dental information to the above-named individual/entity as follows: (check only one)

❑ I authorize Companion Life Insurance Company to disclose any protected health/dental information (except psychotherapy notes) that the above-named individual/entity may request. If applicable, this information may include information pertaining to chronic diseases, behavioral health conditions, communicable diseases including HIV or AIDS, and/or genetic information.

_____ Also include any alcohol and substance abuse records, if applicable.* (*Indicate by Initialing*)

❑ I authorize Companion Life Insurance Company to disclose ONLY the following protected health/dental information to the above-named individual/entity:

_____

3. Purpose. This authorization is made:

☐ At my request.

☐ Only for the following purpose(s): _____

4. Expiration and Revocation.

I understand that I may revoke this authorization at any time by providing written notice of my revocation to Companion Life Insurance Company at the address listed below. I understand that revocation of this authorization will *not* affect any action taken by Companion Life Insurance Company in reliance on this authorization before my written notice of revocation was received.

I understand that this authorization will expire 12 months after termination of my coverage with Company Life Insurance Company, unless earlier revoked by me or my personal representative.

5. Signature. (A separate form must be completed by any individual age 18 or over who wishes to grant authorization.)

I am making this authorization voluntarily and have had full opportunity to read and consider the contents of this authorization. I understand that Companion Life Insurance Company will not condition my enrollment in a health plan, eligibility for benefits, or payment of claims upon my signing this authorization. I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature: _____ Date: _____
(Required) (Required)

Print Name: _____ Member ID Number: _____
(Required) (Required)

If this authorization is completed by a personal representative on behalf of the individual, the personal representative must complete the following and attach legal documentation establishing authority to act as the individual's personal representative.

Personal Representative's Name: _____ Signature: _____

Please return this form to: Companion Life Insurance Company
P.O. Box 100102
Columbia, South Carolina 29202-3102

*This authorization will not apply to alcohol or substance abuse information unless specifically authorized under Section 2.