HIPAA AUTHORIZATION FORM

I, _____, give permission to the following to receive my protected health information from my insurance company:

☐ Indiana State Medical Association (ISMA)

☐ Other: _____

Information to be disclosed (check all that apply):

☐ Claims and deductible information

☐ Other: _____

_____

_____

This protected health information is being disclosed to the Recipients and used by the Recipients for the following purpose(s):

To assist me in determining the status of my deductible and/or with a claim.

This authorization expires when I am no longer enrolled in the ISMA Health Plan.

1) If the person or entity receiving this information is not a health care provider or health plan covered by HIPAA, the information described above may be redisclosed to other individuals or institutions and therefore no longer protected by HIPAA.
2) You may refuse to sign this authorization. Your refusal to sign will not affect your payment, ability to obtain treatment, or eligibility for health plan benefits unless this authorization is requested prior to research related to treatment, enrollment in a health plan, or providing health care that is solely for the purpose of giving that information to a third party, such as to a court for a legal proceeding.
3) You may inspect or copy the protected health information to be used or disclosed under this authorization.
4) You may revoke this authorization in writing at any time by sending a written notification to Thomas Martens at tmartens@ismanet.org. Your notice of revocation will not apply to actions taken by ISMA prior to the date of receipt of the notice.

_____ _____

Signature of Participant or Personal Representative | Date

_____ _____

Printed Name of Participant or Personal Representative | Description of Personal Representative's Authority