LIBERTY UNION LIFE ASSURANCE COMPANY.
560 Kirts Blvd. Suite 125
Troy, MI 48084

Authorization for Release of Protected Health Information

Issued: _____ Effective: _____
Revised: _____ Approved By: _____
Vice President, Compliance Officer

Expires: _____

Policy:

Liberty Union Life Assurance Company and Mid-America Associates, Inc.(hereinafter, jointly referred to as the "Administrator") require an authorization for the disclosure of Protected Health Information (PHI) beyond the restriction established by the HIPAA Privacy standard 45 CFR Parts 160 through 164. Administrator for the self-funded Plan named below, has a valid Business Associate Agreement with the Plan who is the Covered Entity.

PLAN: _____
(Covered Entity)

General Requirements:

1. Administrator will disclose protected health information without an authorization to the individual receiving care, for those activities that are required to carry out treatment, payment, or health care operations except for psychotherapy notes, or those circumstances required by law. The disclosure of any PHI beyond this limitation will require an authorization.
2. An authorization by the individual receiving care or their personal representative will be required by Administrator before disclosing protected health information beyond those limitations established by the Privacy standards.
3. An authorization must contain at least the following elements:
   a. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
   b. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.
   c. An expiration date or an expiration event.
   d. A statement of the individual's right to revoke the Authorization in writing.
   e. A statement that the self-funded plan does not condition payment, eligibility or enrollment of health care services on the individual signing of the authorization.
   f. A signature of the individual and date when Administrator obtained or received a valid authorization for its use or disclosure of protected health information.

SIGNATURE OF EMPLOYEE AUTHORIZING RELEASE OF PERSONAL HEALTH INFORMATION TO AUTHORIZED REPRESENTATIVE:

EMPLOYEE:_____

MEMBER ID NUMBER:_____

GROUP NUMBER:_____

GROUP (EMPLOYER) NAME:_____

THE AUTHORIZED REPRESENTATIVE IS APPOINTED FOR:

NAME (PATIENT)_____

RELATIONSHIP:_____

_____ _____

SIGNATURE OF PATIENT (CHILD IF AGE 18 YEARS OR OLDER) DATE

_____ _____

SIGNATURE OF EMPLOYEE (IF PATIENT IS A MINOR) DATE

AUTHORIZED
REPRESENTATIVE:_____ _____

PRINT FULL NAME DATE

SIGNATURE OF AUTHORIZED REPRESENTATIVE:_____

ADDRESS & TELEPHONE NUMBER OF ASSIGNED AUTHORIZED REPRESENTATIVE:

_____

_____

RETURN TO ADMINISTRATOR:

LIBERTY UNION LIFE ASSURANCE COMPANY / MID-AMERICA ASSOCIATES

560 KIRTS BLVD. SUITE 125

TROY, MI 48084

FAX: (248) 583-4647

LIBERTY UNION
LIFE ASSURANCE COMPANY