SURENCY FLEX & SURENCY VISION AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURE

Insured's Name _____ Date of Birth _____

Insured's Address _____

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED

- ☐ Demographic Information
- ☐ Payment Records
- ☐ Dental Records
- ☐ Other Medical Records
- ☐ Billing Records
- ☐ Other _____
- ☐ All Records*

**"All records" means all protected health information in a designated record set, which includes but is not limited to patient family histories, genetic information, dental, HIV/AIDS, physician records, office notes, narrative summaries, telephone messages, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices (this includes all records including records from other health care providers)."*

Persons, facility, or class of persons who are authorized to disclose (provide) the records/information _____

Persons, facility, or class of persons who are authorized to receive the records/information _____

Expiration: This "Authorization" will expire on _____(MM/DD/YY) or on the following specific event: _____ _____**.** If this item is left blank, the authorization shall remain effective for 60 days after the date listed below.

- This request for disclosure of medical records/information is made at my request for (state reason for the disclosure):_____ .
- I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be re-disclosed and no longer protected by those regulations.
- I also understand that certain records may be protected by federal or state law and I am requesting that any and all such protected records be released under this authorization.
- I also understand that I may revoke this authorization at any time by delivering/mailing a written revocation to the party or attorney or law firm named above.
- If I revoke this authorization it will have no effect on actions already taken on reliance on this form.
- I also understand that the covered entity will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I also understand that I may have a copy of this form after I sign it.
- I authorize the disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization

_____ _____

Signature of Patient (*or Patient's Personal Representative, if applicable*) **Date of Signature**

Personal Representative's Relationship/Capacity to Patient (*if applicable*) _____

Printed Name of Personal Representative (*if applicable*) _____

Printed Address & Telephone Number of Personal Representative (*if applicable*) _____

Return completed form back to Surency at fax: 316-272-4841
or mail: P.O. Box 789773, Wichita, KS 67278-9773
866-818-8805 | Surency.com