Authorization to Obtain and Release Medical Information
This authorization is intended to comply with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

Complete this form and return to:
(*An authorized representative may complete this form if the insured is unable to do so)*

Alaska Care Claims
P.O. Box 13431 Pensacola FL 32591
Phone:888-287-7116
Fax: 866-383-4498

Insured Name: _____ Date of Birth: _____

I hereby authorize the following uses and disclosures of health information about me.

1. The health information that I am authorizing to be used or disclosed consists of all of the following information:
My medical records and medical history; and other information that relates to:
- The diagnosis of any physical or mental condition,
- The treatment of prognosis of any physical or mental condition,

whether such treatment is in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs; alcohol or drug abuse; and communicable or infectious conditions such as AIDS, or sexually transmitted diseases.

2. The following persons or entities are authorized to disclose health information about me: A doctor; medical practitioner; hospital; clinic or medical or medically-related facility; pharmacy or pharmacy benefit manager; or any insurance or reinsurance company (including Kanawha Insurance Company); any consumer reporting agency such as the Medical Information Bureau, Inc. (MIB) or any other organization, institution, or person having health information about me.

3. Health information about me may be disclosed to Kanawha Insurance Company and its affiliates, service providers, Kanawha Insurance Company's agents, and representatives, and to any consumer reporting agency such as the MIB.

4. Health information about me may be used or disclosed to evaluate or process any claim for long-term care insurance benefits or to service my long-term care insurance coverage. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization. For example, we may be obligated to disclose health information to government, regulatory, and law enforcement entities.

5. Kanawha Insurance Company is authorized to disclose health information about me to the individuals designated below. (You should consider listing your spouse, partner, children, and/or any other family member or friend with whom you may want Kanawha Insurance Company to discuss your claim.)

Print Name:_____ Phone No.:_____

Print Name:_____ Phone No.:_____

Print Name:_____ Phone No.:_____

Print Name:_____ Phone No.:_____

6. I understand that:
- If I do not sign this Authorization, Alaska Care may decline to pay any claim for long-term care insurance benefits.
- Although an authorization may generally be revoked by sending a written request to Alaska Care, there is no right to revoke this Authorization if my claim for benefits may be contested by Alaska Care or if Alaska Care has already relied and acted upon this Authorization.
- My health information may be re-disclosed and no longer protected by HIPAA if the person receiving my health information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as Alaska Care and health care providers. However, Alaska Care does require its agents and service providers to protect the confidentiality of health information.
- A copy of this Authorization is as valid as the original.
- I will receive a copy of this Authorization.
- This Authorization expires when coverage under my long-term care insurance policy terminates.

_____	_____	_____	_____
Insured Signature (or Power of Attorney)	Printed Name	Policy Number	Date

If this Authorization is signed by a Power of Attorney (POA) for the insured, a copy of the POA document must be included