WICHITA NATIONAL LIFE INSURANCE COMPANY

AUTHORIZATION FOR ACCESS BY PATIENT OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____ **Social Security #:** _____

I hereby authorize the use or disclosure of protected health information about me as described below:

- The following specific person, class of persons or facility is authorized to disclose protected health information:

- The following specific person, class of persons or facility may receive the disclosed protected health information:

Wichita National Life Insurance Company ~ PO Box 1709 ~ Lawton, OK 73501 ~ (580) 353-5776

Information authorized for use or disclosure, or to be obtained:

- ☐ Psychotherapy Notes (if checking this box, no other boxes may be checked)
- ☐ Mental Health Records
- ☐ Entire Medical Record (includes all records except Psychotherapy Notes)
- ☐ Pathology Report ☐ History and Physical ☐ Operation Report(s) ☐ Progress Notes
- ☐ Consultation Report(s) ☐ Discharge Summary ☐ EKG Report(s) ☐ Physician's Orders
- ☐ Laboratory Report(s) ☐ Radiology Report(s) ☐ Alcohol or Drug Abuse Records
- ☐ Other: _____

The dates of treatment that should be released on the above are from _____ to _____.

The information will be obtained, used, or disclosed for the following purpose(s) only:

- ■ Insurance ☐ Continued treatment ☐ Legal ☐ At the request of the patient or patient's representative
- ☐ Other (specify) _____

I understand:

- I may revoke this authorization at any time, in writing to Wichita National Life Insurance Company, except revocation will not apply to information already used or disclosed in response to this authorization. The recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements (42 C.F.R. Part 2). Unless revoked or otherwise indicated, the automatic expiration date will be **ONE YEAR** from the date of signature or upon occurrence of the following event: _____
- I release the entities listed above, their agents and employees, from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of this form.
- This authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- There is a potential for the protected health information used or disclosed under this authorization to be re-disclosed by the recipient and may no longer be protected under current HIPPA privacy regulations.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS, WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.

_____ _____

Signature of Patient Date of Signature

********OR********

_____ _____

Signature of Guardian, Personal Representative or Next of Kin Date of Signature

(Guardian/representative must provide written proof of authorization to act for the individual)

P.O. BOX 1709 ● LAWTON, ● OK. ● 73502 ● Phone (580) 353-5776 ● Fax (580) 353-6482

Attachment For HIPAA Release Form

*****Please make sure you list all Physicians/Hospitals that treated you in the past 3 years. Failure to do so may cause a delay in processing your claim/application.*****

CURRENT DOCTOR(S) INFORMATION

Doctor # 1

Name: _____

Address: _____

_____

Phone Number: _____

Date of First Visit: _____

Date of Last Visit: _____

Doctor # 2

Name: _____

Address: _____

_____

Phone Number: _____

Date of First Visit: _____

Date of Last Visit: _____

Doctor # 3

Name: _____

Address: _____

_____

Phone Number: _____

Date of First Visit: _____

Date of Last Visit: _____

Doctor # 4

Name: _____

Address: _____

_____

Phone Number: _____

Date of First Visit: _____

Date of Last Visit: _____