SEVENCORNERS

Authorization of Use and Disclosure of Privacy and Claims Information

Complete this form if you wish to authorize Seven Corners to discuss Protected Health Information with a person you choose.

Call for help: 800-335-0611 (toll free)
or 317-575-2652 (worldwide)
or 317-818-2809 (collect)

Email
claims@sevencorners.com
(email attachments can not be larger than 10 MB.)

Fax
317-575-2256

Name of Insured

Date of Birth

Certificate Number

Certificate Number (Write "ALL" if wish for this authorization to apply to all certificates under which you are insured.)» Your certificate number will be shown on your ID card. If you are unable to find your certificate number, call Seven Corners.

Name of the Individual you authorize Seven Corners to discuss protected health Information

Relationship to Insured

Optional,

☐ The Individual named may correct or make changes to the policy under which I am insured.

Effective Date: This authorization is effective on the date received by Seven Corners.

Expiration Date

(If no expiration date is provided, this authorization will expire 1 year after the date of signature.)

Your records are confidential and cannot be disclosed without your written authorization except when otherwise permitted by law. If you have authorized Seven Corners to disclose information, that information may be subject to re-disclosure by the person or entity receiving it and then would no longer be protected by federal privacy regulations. Your signature below affirms that you agree to the above terms of disclosure and use for the personal health information and other private information.

Signature for persons 18 years of age or older*

Date

*If you are the legal representative of a person age 18 years or older, please sign in this space and attach evidence of such representation.

Signature of parent or guardian for persons under 18 years of age

Date

Name Printed

Relationship