SEVEN CORNERS

RELEASE OF INFORMATION

Authorization of Use and Disclosure of Personal Health Information

Completion and submission of this form authorizes Seven Corners, Inc. to use and disclose the information indicated below.

Name of Insured:			
Policy #:		**Date of Birth:**	
Name of Insured's Guardian or Legal Representative:			
☐ **All personal health information may be used or disclosed** ☐ **Only personal health information indicated may be used or disclosed ➔**			
Disclose personal health information indicated above to:	**Person/Organization:**		
	Address:		
	Relationship:		
Expiration date of this authorization*:			

**This authorization is effective upon receipt by Seven Corners through the date indicated above unless revoked or terminated by the insured or insured's representative. If no expiration date is provided this authorization will expire 12 months after the signature date below.*

Right to Terminate or Revoke Authorization:

You may revoke or terminate this authorization by submitting a written revocation to Seven Corners, Inc. at the following address.

Seven Corners
Attn: Privacy Officer
PO Box 211760
Eagan, MN 55121 USA

Risk of Re-disclosure:

The person or organization indicated above may provide information disclosed under this authorization to others. The privacy of this information may not be protected under the federal privacy regulations in such situations. Seven Corners does not assume responsibility for the use of this information by said person or organization.

Approval Signature

Your signature below affirms that you agree to the above terms of disclosure for the specified personal health information.

Insured (Guardian/Legal Representative) Signature	**Date**

Mail the completed and signed form to Seven Corners at the address indicated above.

Retain a copy of this document for your records.