AUTHORIZATION FOR THE USE AND DISCLOSURE OF INFORMATION

This authorization applies to Allstate Health Solutions, Time Insurance Company, Integon National Insurance Company, Integon Indemnity Corporation, and American Heritage Life Insurance Company and its third party administrator, (including, but not limited to, Meritain Health), collectively referred to herein as "Allstate Health Solutions". It must be dated and signed by the individual or by a person authorized by law to give this authorization. File copy and facsimile transmission are considered equivalent to the original. If the authorization from an individual is requested for use or disclosure of Protected Health Information (PHI), a copy of this signed authorization shall be provided.

Member Name:____

Member Address: ____

Member Policy/ID No.: __________________ Telephone No.: __________________ Last (4) Digits of SSN: ________________

I, or my legal representative, authorize Allstate Health Solutions to use or disclose my personal health information to the person/entity identified below, including, but not limited to, medical, claim, and benefit records, and any individually identifiable health information contained in these records, as requested by such person/entity. I understand these records may contain information created by other persons or entities, including physicians and other health care providers as well as information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services, reproductive health services, and treatment for sexually transmitted diseases. Allstate Health Solutions does not collect, nor am I required to provide genetic information for the purposes of underwriting or determining eligibility for coverage. However, the documents being disclosed may include information related to genetic testing which was collected incidentally and/or related to a claim for services.

Persons/entities authorized to receive the information (including address of where information should be sent, if applicable):

Name:____

Address: ____

I understand that:

- My health record is private and is known under the law as “Protected Health Information (PHI)”
- Allstate Health Solutions policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law.
- This authorization is voluntary. I may refuse to sign and my refusal will not affect my enrollment in a health plan, eligibility to receive benefits, ability to obtain treatment, or ability to receive payment for treatment, unless allowed by law.
- I may revoke this authorization at any time by notifying Allstate Health Solutions in writing to Attention: Allstate Health Solutions Privacy Department, PO Box 2070, Milwaukee, WI 53201-2070. Revoking this authorization will not have any effect on actions that Allstate Health Solutions took in reliance on the authorization before notification was received.
- This authorization expires on ____________[date] or is valid until____________________[event]. If a date or event is not provided, then the authorization will expire one year from the signature date or one year following the termination of my relationship with Allstate Health Solutions, whichever is later.
- Once health information about me has been disclosed by Allstate Health Solutions to a third party, the health information may no longer be protected by federal privacy laws.

______________________________ ____________________

Signature Date

____

Print Member Name or Name of Member’s Authorized Representative

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If Authorized Representative, please describe relationship to Member and authority to sign for Member

Allstate Health Solutions is a marketing name for products underwritten by National Health Insurance Company, Integon National Insurance Company Integon Indemnity Corporation, and American Heritage Life Insurance Company.
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