

## POLICYHOLDER AUTHORIZATION TO RELEASE INFORMATION

Policyholder name \_\_\_\_\_

Lisle, IL 60532

www.ilhiga.org

PLEASE PRINT

Policy number \_\_\_\_\_

AUTHORIZATION: I authorize Illinois Life & Health Insurance Guaranty Association, hereinafter referred to as "ILHIGA," to release written and/or verbal information about my insurance policy and claim, including my medical care and treatment and other non-medical information as deemed necessary by ILHIGA, to the following individuals:

| Name (please print) | Relationship | Telephone number |
|---------------------|--------------|------------------|
|                     |              |                  |
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**REVOCATION:** I understand that I have the right to revoke this authorization. Such revocation must be sent in writing to ILHIGA at PO Box 4198, Lisle, IL 60532 or ILClaims@illinoisga.org and will become effective when received by ILHIGA. I understand that even if I revoke this authorization, ILHIGA will, and will be permitted to disclose information as required or permitted by law and as permitted by other authorizations I have given ILHIGA, and in accordance with its notices of information practices.

DISCLOSURE AND REDISCLOSURE: ILHIGA cannot guarantee that the individuals I have authorized will not disclose or re-disclose my personal information. If disclosed under this authorization, protected health information is no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) and state and federal laws.

PERIOD OF VALIDITY: This authorization shall be valid from the date signed for either six (6) months, or as long as my policy remains in force, whichever is later, unless revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original.

| Signed  | Date   |
|---|--|
| Name (please print)                           |  |
| If this authorization is signed by a personal | or legal representative of the applicant/insured, complete the following:      |
| Personal/legal representative's name          |  |
| Relationship to applicant/insured             |  |
| Basis for representation (POA, guardian       | n, etc.)   |
|   | PLEASE ATTACH COPY OF LEGAL DOCUMENT   |
| Please submit your completed for              | rm using one of the options below. For further assistance please contact us at |
| Email:  | : ILClaims@illinoisga.org  |
| Fax:  | 773.304.3559   |
| Mail  | PO Boy 4108  |

Mail: PO Box 4198 Lisle, IL 60532