AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

(Authorized Representative)

I, _____ *(covered person's name)*

residing at _____ *(address)*

hereby authorize Dunn and Associates Benefit Administrators Inc. to disclose my protected health information (PHI)

to _____ as follows:

Purpose of Disclosure:

- ☐ For assistance in claim payments or processing
- ☐ For assistance in disputing claim denials, in whole or part
- ☐ Other: _____

Information to be Disclosed:

- ☐ Enrollment Information
- ☐ Claims Payment Information
- ☐ Diagnosis/Procedure Information
- ☐ Pre-certification/Concurrent Review Information
- ☐ Other (Description): _____

I understand that this authorization is voluntary. I understand that Dunn and Associates cannot guarantee that disclosed information will not be redisclosed to a third party or that the information will be protected by federal and state law governing the use and disclosure of protected health information.

I understand that this authorization will remain in effect until_____ (upon termination of my health coverage if no expiration date provided) or until I provide a written notice of revocation to Dunn and Associates Benefit Administrators, Inc.

I agree that a copy of this authorization may be considered as valid as the original.

_____ _____

Signature of Covered Person Date

_____ _____

Employer Employee's ID

Return completed from to: Dunn & Associates

Mail: PO Box 2369 Columbus, IN 47202-2369 - Fax (812) 378-9967 - Email: info@dunnbenefit.com