NAHGA Claim Services

National Accident & Health General Agency, Inc.
P.O. Box 189
Bridgton, ME 04009-0189
(800) 952-4320

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Member Name: _____

SSN: _____

DOB: _____

Policy: _____

Adjuster: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated):

   ___ Problem/Diagnosis History

   ___ Medical Bills submitted to NAHGA for payment by student insurance

   ___ Payments made by NAHGA on my behalf through student insurance

   ___ Any other pertinent information relating to the payment/processing of my medical claims

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. The information identified above may be used by or disclosed to the following individuals or organization(s):

   Name: _____

   Address: _____

   _____

5. This information for which I'm authorizing disclosure will be used for the following purpose:

   Processing/Payment of Health Insurance Claims by NAHGA Claim Services

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to NAHGA, Inc. I understand that revocation will not apply to information that has been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. This authorization shall expire on (insert date or event): _____
   If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

8. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure payment of healthcare claims.

_____ _____

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient _____

Distribution of copies: Original to NAHGA, Inc., copy to patient; copy to accompany use or disclosure.