Colonial Life

8485 Goodwood Boulevard
Baton Rouge, LA 70806
Phone: (888) 400-9304 or (225) 400-9304
www.ColonialLife.com

Authorization for Release of Health Information

Return completed form via fax **(855) 400-9307**, or mail to the address above.

Patient Information			
Patient Name (Last name, First name, MI):	Patient's birth date: _____ / _____ / _____ MM DD YY		
Previous Name(s):	Patient's Social Security Number/Member ID:		
Patient Mailing Address:	City:	State:	Zip code:

This will authorize Colonial Life to use and/or disclose the following protected health information as described below:

1. Specific description of my protected health information (including dates):

_____

_____

2. Persons or organizations receiving my protected health information:

_____

_____

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I understand that I may inspect or copy the protected health information which is subject to this authorization.	_____
I understand that this authorization may be revoked in writing at any time, by delivery to Colonial Life, subject to any action that has already been taken.	_____
I understand that information used and/or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and, if so, may no longer be protected by federal or state privacy laws.	_____
I understand that Colonial Life shall not condition payment of benefits, enrollment in the health plan, or eligibility for benefits under the health plan on my providing authorization for the requested use and/or disclosure and THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.	_____
I understand that Colonial Life may receive direct or indirect renumeration from the persons or organizations listed in item 2 above as a result of this authorization.	_____

Signature

Signature of patient or representative: _____ **Relationship to patient:** _____

Date: _____

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