SuperiorVision
by VersantHealth

Authorization for disclosure of protected health information

Person granting authorization

Name: _____ **Address:** _____

Date of birth: _____ _____

Policy holder information

ID number: _____ **Address:** _____

Name: _____ _____

Telephone: _____

I authorize and direct Superior Vision, Inc. and its affiliates to furnish and release vision care insurance information regarding the person noted above.

Information to be disclosed

_____ Participating Vision Care Providers

_____ Benefit, Policy and Procedure information

_____ Vision Care Claims Information

_____ Vision Care Claims Review Information

_____ Eligibility Information

_____ Other _____

Purpose of disclosure

_____ To provide information to a family member or friend

_____ As required for a legal matter

_____ Other

_____

Person(s) or organization(s) to receive the identified information

Name: _____ **Name:** _____ **Name:** _____

Street address: _____ **Street address:** _____ **Street address:** _____

City, state, ZIP: _____ **City, state, ZIP:** _____ **City, state, ZIP:** _____

My protected health information is information about me, including information such as my name and address and/or medical information. The information was used or created when I received vision care or when payment was received for my vision care. The information may include my past, present or future vision health care or condition.

I understand that if the persons or organizations I authorize to receive and/or use the protected health information described above are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that my authorizing the use and disclosure of my "protected health information" is not a condition of my enrollment in the Superior Vision Care plan, my eligibility for benefits or payment of my claims.

Expiration: This authorization will expire on ____/____/____ or on occurrence of the following event _____

Right to revoke: This authorization may be revoked at any time. Contact Superior Vision, Inc. at 1 (800) 923-6766 for further instructions. Revocation of this authorization will not affect any action taken before Superior Vision, Inc. receives the notice of revocation.

Signature (person requesting authorization): _____ **Date:** _____/_____/_____

If this form is signed by a personal representative on behalf of the individual, complete the following:

Personal representative's name (please print):

_____

Description of personal representative's authority (please print):

_____ **Note:** Please retain a copy of this signed authorization for your records.

Instructions for completing the authorization form

Please read the instructions below before completing the Authorization form. The information you provide will be used to fulfill your request to disclose your protected health information and identify the person(s) who will be receiving your information. All required sections of the form must be completed in order for us to process this request. If required information is not completed, we will not disclose your protected health information. In certain circumstances, a written authorization to disclose your protected health information to a third party specified by the individual is required by law.

Section 1 – Member information (required)

This section must be completed with the information specific to the individual. A contact number or address is needed in case additional information or clarification is required.

Section 2 – Granting authorization/specification of information to be disclosed (required)

Select the type of Protected Health Information to be disclosed. If OTHER, specify what information you wish disclosed.

Section 3 – Purpose of disclosure (required)

Select the purpose of this authorization to disclose Protected Health Information. If OTHER, specify the reason for the authorization.

Section 4 – Designate the recipient(s) (required)

Identify to whom the requested information is to be provided.

Section 5 – Important information (required)

Please read this section carefully

Section 6 – Expiration / revocation of an authorization (required)

You must indicate a date or event that will trigger the expiration of this authorization. Once an authorization has expired, the person who has been receiving your information will no longer be able to receive your information. If an event will trigger the expiration of this authorization, please indicate that event in the space provided.

Section 7 – Signatures and personal representatives (required)

The individual whose information is being disclosed must sign and date in the space provided. If this form is completed by your personal representative, he or she must include his or her name and relationship to you. (e.g. attorney-in-fact, guardian, executor, parent of a minor, etc.).

Please return the completed authorization form to the address below:

Mail: Attn: Customer Service, PO Box 509, Troy NY 12181

Fax: 1-866-999-4640