STERLING℠
INSURANCE

Authorization for the Use and Disclosure of Your Protected Health Information
Form Instructions

Enclosed is the form *Authorization for the Use and Disclosure of Your Protected Health Information*. Please be advised that this form is a legal document and you may wish to seek the advice of a legal counsel.

By signing this document, you will authorize Sterling Life Insurance Company to allow the person of your choosing to have access to your protected health information. Protected health information is any health information through which you can be identified.

This form does not authorize the person of your choosing to change information within the scope of your policy, including change of address or banking information.

Upon completion of the form, please mail it to the address below:

Sterling Life Insurance Company
P.O. Box 5348
Bellingham, WA 98227-5348
Or Fax to: 1-888-858-8552

If you have any questions, please contact Sterling Customer Service Monday through Friday, 5:00 a.m. to 5:00 p.m. Pacific Time, excluding company holidays. Our toll free numbers are 1-800-688-0010 or TTY 711 for the hearing impaired. We will be happy to assist you.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

Policyholder: _____ Policy Number: _____ Date: _____

AUTHORIZATION SECTION:

I authorize the use and disclosure of my Protected Health Information as described below. I understand that the authorized persons or entities described below will only use and disclose my Protected Health Information in accordance with this Authorization.

I authorize the following person(s) or entities to *disclose* my Protected Health Information as described below:

Sterling Life Insurance Company

I authorize the below-named person to *receive* my Protected Health Information as described below:

_____	_____	(____)_____-_____
Authorized Person's Name	Relationship	Phone Number

I understand and agree that my Protected Health Information may and will only be used and disclosed for the following purpose(s):

Any and all information regarding claims on my policy. Any and all information regarding my premium payments. To include: claim payment status, denied claim explanations, whether or not a claim has been received from a specific provider, premium amounts, premium payment status and history, checking account information such as account and routing numbers, current and past address information, and benefit details.

IMPORTANT INFORMATION ABOUT YOUR RIGHTS:

- I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my treatment, payment for my health care services, or enrollment in a health plan or eligibility for benefits.
- I understand that any Protected Health Information disclosed pursuant to this Authorization to a third party that is not covered by state or federal privacy law may be subject to redisclosure by the recipient and no longer protected by federal or state law.
- I understand that I may revoke this Authorization at any time by submitting my written request for revocation to Sterling Life Insurance Company, 2219 Rimland Drive Bellingham, WA 98226, Attention: Privacy Officer and that my revocation will be effective immediately upon receipt. However, I understand that my revocation will not be effective to the extent that a third party has taken action in reliance on this Authorization for a use or disclosure of my Protected Health Information prior to receiving my revocation.
- I understand that this Authorization will be effective until 60 days following the date I am no longer a policyholder under any policy offered or provided by Sterling Life Insurance Company.

BY SIGNING THIS AUTHORIZATION FOR RELEASE OF MY PROTECTED HEALTH INFORMATION, I UNDERSTAND AND AGREE TO THE STATEMENTS CONTAINED HEREIN AND AUTHORIZE THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED HEREIN.

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Signature of Policyholder Date

A COPY OF THIS AUTHORIZATION MUST BE PROVIDED TO THE INDIVIDUAL.

THIS AUTHORIZATION IS IN COMPLIANCE WITH THE UNIFORM HEALTH CARE INFORMATION ACT AND WITH FEDERAL STATUTE 45 CFR, PART 164.