ADMINISTRATIVE CONCEPTS, INC.

997 Old Eagle School Road Suite 215 Wayne, PA 19087-1706
Telephone (610) 293-9229 Fax (610) 293-9299 www.visit-aci.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION NEEDED TO ASSIST IN THE DETERMINATION OF THE STATUS OF A CLAIM FILED AGAINST THE STUDENT MEDICAL INSURANCE POLICY

I hereby authorize Administrative Concepts, Inc. to obtain and *disclose* **Protected Health Information** and disclose such information to the individual(s) indicated below, for the *express* and *limited* purpose to assist in the processing of my claim.

Information to be Used or Disclosed May Include:

[X] Provider name, address & specialty (required)
[X] Dates of service (required)
[X] Cost of services (required)
[X] Medical diagnosis (optional)
[X] Services rendered (optional)
[X] Medications (optional)

Persons or Class of Persons to Whom the Disclosure May be Made:

[ ] Student Health Service Staff
[ ] Student Affairs Staff
[X] A Specific Individual(s), as follows: Susan Ewing, Joshua Cameron, Tara Wilkerson, of Jefferson Laboratory

I understand that individually identifiable health information relating to me, which is called *Protected Health Information* as defined by the *Privacy Rule* of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA);* and,

that if the person or entity that receives this information is not a health plan, health care clearinghouse, or health care provider as defined in the regulation text of the *Privacy Rule*, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law; and,

that I may revoke the authorization at any time by notifying Administrative Concepts, Inc. *in writing*. However, if I choose to do so, my revocation will not affect any actions taken by Administrative Concepts, Inc. *prior* to my revocation; and,

that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on 09/30/2013.

Insured Name: (print) _____

ID or Social Security Number: _____-____-_____ **Date of Birth: ____/____/____**

Claimant is: [ ] Self **[ ] Dependent (print full name and indicate relationship to insured)**

_____

Patient's or Authorized Representative's Signature: _____

Date: ____/____/____ **If Authorized Representative, Relationship to Patient:_____**