

**CONSENT AND AUTHORIZATION**

**FOR THE USE AND DISCLOSURE OF PERSONALLY IDENTIFIABLE FINANCIAL INFORMATION**

Pursuant to Section 502(e)(2) of the Gramm-Leach-Bliley Act of 1999 (“GLB”), I hereby consent to and authorize the use and/or disclosure of my personally identifiable financial information as described below:

1. My consent and authorization applies only to that certain information generated by Kanawha HealthCare Solutions, Inc. [Kanawha Insurance Company] in its role as Third Party Administrator for Kanawha Insurance Company and related to the payment of past claims and/or the status of existing claims submitted by me or by an authorized representative on my behalf pursuant to the terms of my \_\_\_\_\_ Policy Number # \_\_\_\_\_ (the “Policy”). Only this information may be used and/or disclosed pursuant to this Consent and Authorization.
2. I authorize only the designated staff of Kanawha HealthCare Solutions, Inc. [Insurance Company] to make use of and/or disclose my personally identifiable financial information for the purposes described herein.
3. I authorize only \_\_\_\_\_ (*Licensed Agent/Broker*) to receive, in writing or by phone, that certain personally identifiable financial information described above for the purpose of providing a service to me in relation to the Policy.
4. I understand that if my personally identifiable financial information is disclosed to someone who is not required to comply with GLB, and/or equivalent state law, then such information may be re-disclosed and would no longer be protected.
5. I understand that I have the right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Kanawha Insurance Company, 210 South White Street, P.O. Box 7200, Lancaster, SC 29721-7200. This revocation shall become effective on the date it is received by Kanawha Insurance Company. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.
6. This Authorization is valid for twenty-four (24) months from the date of execution hereof.

**I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS CONSENT AND AUTHORIZATION AND HEREBY CONSENT AND AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PERSONALLY IDENTIFIABLE FINANCIAL INFORMATION AS SET FORTH HEREIN.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Policyholder

I have legal authority under the laws of the State of \_\_\_\_\_ to make health care decisions on behalf of \_\_\_\_\_, the individual to whom the use and/or disclosure of personally identifiable financial information above applies, and execute this Consent and Authorization in my capacity as Personal Representative thereof.

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Policyholder