

KANAWHA INSURANCE COMPANY

210 South White Street, Post Office Box 610  
Lancaster, South Carolina 29721-0610

AUTHORIZATION FOR THE USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION

***PLEASE COMPLETE AND FORWARD WITH APPLICATION FOR COVERAGE.***

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to that certain information obtained by Kanawha Insurance Company from any Licensed Health Care Practitioner, including a licensed physician, licensed nurse, medical practitioner, hospital, clinic, home health care agency, nursing home, or other medical or medially related facility; employer; consumer reporting agency; insurance company; or the Medical Information Bureau, and utilized for the purpose of providing written notice disclosing the reason(s) for an Adverse Underwriting Decision in the course of declining coverage or making a counteroffer for alternative coverage. Only this information may be used and/or disclosed pursuant to this Authorization.
2. I authorize only the designated staff of Kanawha Insurance Company to make use of and/or disclose my protected health information for the purposes described herein.
3. I authorize only \_\_\_\_\_ (Licensed Agent) to receive, in writing, that certain protected health information related to an Adverse Underwriting Decision or counteroffer for alternative coverage for the purpose of providing assistance to me in the procurement of coverage from a different insurance carrier.
4. I understand that if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, 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, Post Office Box 7200, Lancaster, South Carolina 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 ninety (90) days from the date of execution hereof.
7. I understand that I do not have to sign this Authorization and that my refusal to sign will not affect my eligibility for coverage.

**I certify that I have received a copy of this Authorization and authorize the use and/or disclosure of my protected health information as set forth herein.**

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Applicant

\_\_\_\_\_ Printed Name of Applicant

**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 protected health information above applies, and execute this Authorization in my capacity as Personal Representative thereof.**

\_\_\_\_\_ Date

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

\_\_\_\_\_ Relationship to Applicant