AUTHORIZATION

FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 medically related facility, employer, consumer reporting agency, insurance company or the Medical Information Bureau, and utilized for the purpose of providing claim status and payment history information.
2. I authorize only the designated staff and employees of the Policy Administration and/or Claims Department of Kanawha Insurance Company to make use of and/or disclose my protected health information for the purposes described herein.
3. I authorize only _____ to receive, in writing or by telephone, the claim status and/or payment history information listed below. Only this information may be used and/or disclosed pursuant to this Authorization.
4. I understand that Kanawha Insurance Company will not condition the payment of benefits based on my agreement to sign this Authorization.
5. I understand that that if I authorize you to disclose my protected health information 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.
6. I understand that I have a right to revoke this Authorization at any time. My revocation must be submitted in writing to Kanawha Insurance Company, 210 South White Street, P.O. Box 610, Lancaster, SC 29721. This revocation shall become effective on the date it is received by the Policy Administration Department of 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.
7. This Authorization is valid for twenty-four (24) months from the date of execution hereof.
8. I authorize the release of information related to any of the following:
   Provider's Name: _____
   Provider's Address: _____
   Dates of Service: _____
   Policy Number (Required):_____

I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS AUTHORIZATION AND AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS CONTEMPLATED HEREIN.

_____ _____ _____

Signature Print Name Date

This section to be completed only by parent, legal guardian, or Power of Attorney

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 Authorized Representative thereof.

_____ _____ _____

Name of Authorized Representative Relationship to Applicant Date

Parent or Guardian

* A copy of the legal authority document must be on file with Kanawha Insurance Company.

Kanawha Insurance Company
210 South White Street
Lancaster, SC 29720