Patient Authorization Form

Name of Patient:_____ Date of Birth:_____
SS#:_____ Purpose of release: TRAVEL INSURANCE CLAIM

DOCTORS AND/OR MEDICAL FACILITIES AUTHORIZED TO RELEASE MY HEALTH INFORMATION:

Name	Address	Telephone	Fax	Dates Treated

You are authorized to release any health information that may have bearing on the request for benefits submitted in conjunction with the travel protection plan to: CSA Travel Protection and Insurance Services, its affiliates, underwriters, reinsurers, and any agent expressly acting on behalf of CSA Travel Protection and Insurance Services. Additionally, if there is potential fraudulent activity you release medical information related to the identification and prevention of the fraudulent activity to the underwriters, insurance support organizations, fraud information clearinghouses and designated service providers assisting in the processing of the claim.

Send to: CSA Travel Protection and Insurance Services
Attn: Claims Department, P.O. Box 939057, San Diego CA 92193-9057
FAX: 877-300-8670. Information to be released: Physician Dictation, Physical and/or Occupational Therapy Records, Office Notes, Lab Reports, Entire Record,
Other: _____

I UNDERSTAND THE FOLLOWING:

- If applicable, HIV/AIDS, genetic testing, abuse, drugs/alcohol and/or mental health records will be included in the health information that is released.
- I may revoke this authorization to the health information management department in writing. My revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless revoked, this authorization will expire in six months.
- I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. Any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I am entitled to a copy of this authorization. A facsimile or photocopy can be treated as the original.
- THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.
- My treatment, payment, or enrollment may not be conditioned on signing this authorization. If I refuse to sign this authorization, benefits may not be paid under the travel protection plan if additional health information is needed to determine my eligibility for benefits.

Signature of patient or authorized person Date:

Relationship/Reason patient is unable to sign