Nippon Life Benefits®

Mailing Address:
P.O. Box 25951
Shawnee Mission, KS 66225-5951
FAX: 913-387-5920

Member or Member's Dependent Authorization for Disclosure of Health Information – All States
(Applicable to Group Medical, Dental, and Vision Customers)

This authorization complies with the HIPAA Privacy Rule

1. I initiate this authorization for disclosure of my health information (defined in #2). I authorize Nippon Life Insurance Company of America (Nippon Life Benefits), its agents, and business associates to disclose my health information as described below. *Statement required by §164.508(c)(1)(ii).*

   a) Please disclose my health information to (check as applicable):

   ☐ My employer/plan sponsor (Please include name and address of employer/plan sponsor): *Statement required by §164.508(c)(1)(iii).*

   Employer: _____

   Attn: _____

   Address: _____

   _____

   ☐ Another person (Please include name and address of person to whom the information is to be released): Statement required by §164.508(c)(1)(iii).

   Name: _____

   Address: _____

   _____

   b) Describe the health information to be disclosed (check as applicable): *Statement required by §164.508(c)(1)(i).*

   ☐ Please disclose any and all health information requested by the person described above.

   ☐ Please describe the health information to be disclosed:

   Description: _____

   _____

   c) Reason for the disclosure (optional): *Statement required by §164.508(c)(1)(iv).*

   _____

   By my signature, I acknowledge that any prior agreements I have made to restrict my health information do not apply to the information released under this authorization.

2. I understand my health information may be used or disclosed as set forth by this authorization. Protected Health Information includes information created or received by Nippon Life Benefits. Protected Health Information also includes but is not limited to*: Statement required by §164.508(c)(1)(i).*

   - Hospital records
   - Treatment records/office notes
   - Alcohol or drug abuse treatment
   - Consultation reports
   - Worker's compensation information
   - Diagnosis
   - Prescriptions
   - Test results
   - Vocational testing/counseling information
   - Benefit information

3. If you are the representative of the person whose information is to be shared (including a parent acting as a representative on a child's behalf) describe the scope of your authority to act on the person's behalf; for example, power of attorney, guardian, conservator: *Statement required by §164.508(c)(1)(vi).*

4. I understand that any information disclosed under this authorization may no longer be covered by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and may be subject to redisclosure. *Statement required by §164.508(c)(2)(iii).*

5. I understand that I may revoke this authorization at any time. The request for revocation must be in writing and sent to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, KS 66225-5951. To request a revocation form, contact the Privacy Officer. I understand that a revocation is not effective if Nippon Life Benefits has relied on the Protected Health Information disclosed to it or has a legal right to contest a claim under an insurance policy or to contest the policy itself. *Statement required by §164.508(c)(2)(i).* Such revocation shall not apply to any use or disclosure of my Protected Health Information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses and disclosures that HIPAA allows without my authorization.

6. This authorization will be valid for 12 months following the date of my signature below. *Statement required by §164.508 (c)(1)(v).*

7. I understand that I am not required to sign this authorization form and that Nippon Life Benefits will not condition the provision of payment of a claim for medical, dental, and/or vision coverage on the signing of this authorization. *Statement required by §164.508(c)(2)(ii)*

I initiate this authorization for disclosure of health information. I have read and I understand this authorization. Upon receipt of your signed authorization, a copy will be provided to you. *Statement required by §164.508(c)(4).* A photocopy of this authorization shall be considered as effective and valid as the original. No alteration of this form will be accepted.

Name of person whose information is to be shared **Date of birth** **I.D. number**

Address of person whose information is to be shared **Phone number**

Employer name **Group number**

Employer address

Name of personal or legal representative (if applicable)

Relationship of personal or legal representative to person whose information is to be shared

If signing on behalf of another, please attach the proper documentation that attests to your ability to sign (Court-stamped Letters of Appointment as Executor of Estate, proof of custody, power of attorney, etc.) *Statement required by §164.508(c)(1)(vi).*

Signature of person whose information is to be shared (or person's representative) ***Date***
Statement required by §164.508(c)(1)(vi).

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