Authorization to Obtain Information

Primary Member's Name:	SSN	Date of Birth
Member ID #		
Address:		
Name of Individual Subject to Disclosure (If not the primary Member):		Date of Birth
Relationship to Primary Member: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Stepchild ☐ Grandchild		

I. Authorization:

For the purpose of evaluating my eligibility for assistance and coverage allowances under an existing policy, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for enrollment and/or claim request form, I hereby authorize the disclosure of the following information (defined below) about me and, if applicable, my dependents, from the sources listed below to Sovereign Nations Insurance (SNI), or any person or entity acting on its part, to include a third party administrator (TPA).

II. Disclosure of Health Information:

Health information may be disclosed by any health care provider, health plan (including SNI or TPA, with respect to other SNI or TPA coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. SNI will not disclose the information unless permitted or required by those laws.

III. Rights and Expiration:

I understand that I may revoke this authorization at any time, except to the extent that SNI or TPA has taken action in reliance on this authorization. If I revoke this authorization, SNI may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to SNI at the address or fax number above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

IV. Notice:

I understand that SNI is not conditioning payment, enrollment, or eligibility for coverage on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health insurance plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

- **If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form**
- **If records are on a minor child the natural parent or legal guardian must sign on their behalf.**

Please return completed form to

Sovereign Nations Insurance
P.O. Box 1810
Draper, UT 84020

or

Fax: 801-274-8900

_____ **(Print Patient's Name)**

_____ **(Print Primary Member's Name)**

_____ **(Patient's Signature)**

_____ **(Primary Member's Signature)**

_____ **(Date signed)**

_____ **(Signature of SNI representitive)**