



Health Reinsurance Association
628 Hebron Avenue, Suite 212
Glastonbury, CT 06033
Phone 1-800-842-0004

HEALTH REINSURANCE ASSOCIATION

Assignment of Personal Representative

I \_\_\_\_\_
(Name) (Date of Birth) (SS Number)

, authorize Health Reinsurance Association to recognize: \_\_\_\_\_
(Name of Representative)

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Policyholder \_\_\_\_\_

as my personal representative for the purpose of:

- granting authorization to release my confidential information to persons other than myself during my lifetime or after my death.
reporting any change in my address.
reviewing my benefits.
authorizing release of information for reasons relating to treatment, payment or healthcare operations.
discussing payment of my premiums.
any other reason

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my written permission to revoke this authorization it will remain in effect indefinitely.

I hereby release the Health Reinsurance Association from all legal liability that might arise from the release of sensitive information and/or information protected Titles of the Code of Federal Regulations. Any further disclosure of my records other than what is outlined above is prohibited without my specific written authorization, or as otherwise permitted by such regulations. I consider a photocopy of this authorization to be as valid as the original.

I understand that I may inspect the information to be disclosed as provided in 45 CFR 164.524.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this rule.

\_\_\_\_\_  
(Policyholder or covered dependent name - please print)

\_\_\_\_\_  
(Policyholder or covered dependent signature)

\_\_\_\_\_  
(Date)