Commercial Travelers Mutual
Insurance Company
School Plans Underwriter and/or Administrator

Permission to Disclose Health Plan Information

Student's Name*	Birth Date	School	Policy Number
Dependent's Name (if applicable)			

*Student or Dependent who wants to allow others to call or receive communication on their behalf.

1. I authorize Commercial Travelers Mutual Insurance Company to discuss or release information identified in paragraph 2, below, to the following individuals:

_____ _____
Name (s) of authorized person(s) Relationship to above member

_____ _____
Name (s) of authorized person(s) Relationship to above member

_____ _____
Name (s) of authorized person(s) Relationship to above member

2. I authorize Commercial Travelers to discuss or release information necessary to process or respond to eligibility inquires, coverage/benefit inquiries, claims inquires, appeals, and complaints about my health insurance coverage with Commercial Travelers and I acknowledge that the information released may include individually identifiable health information about me.

3. This authorization is being made at my request.

4. In signing this authorization, I understand and acknowledge the following (initial in the space provided):

_____ I understand that this authorization is voluntary and that I may refuse to sign it.

_____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

_____ I understand that I may revoke this authorization at any time by notifying Commercial Travelers in writing of my intent to revoke this authorization, except to the extent that action has been taken in reliance on this authorization. Any notice of termination must be sent to the HIPAA Compliance Coordinator, 70 Genesee Street, Utica, New York 13502.

_____ I understand that, unless otherwise revoked, this authorization will expire one year from the date of this permission.

_____ I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

I, the undersigned, do hereby affirm that I am the above-mentioned student or dependent or an authorized legal representative. I have read and understand the above information.

_____ _____
Date Signature of Student or Dependent