WMI® MUTUAL INSURANCE™ COMPANY
AUTHORIZATION FOR RELEASE OF INFORMATION

Based on the federal HIPAA privacy rule, we must obtain an authorization from you in order to use or disclose protected health information (*i.e.*, information regarding your health care or treatment that specifically identifies you) for purposes other than normal health care operations, such as to disclose information to your agent or to any other telephone caller on your behalf for the purpose of verifying eligibility for coverage, checking claims status, or solving claims processing problems. We must also obtain an authorization from you in order to use or disclose psychotherapy notes, and, although not required, an authorization may also be requested from a provider prior to the release of medical records.

Please fill in any blank areas below, and return the form to the address shown at the bottom of this page.

I. The Protected Health Information being requested for use or to be disclosed is as follows:

Patient name: _____ Insured Employee's SS#: _____

Persons/Organizations authorized to disclose the information: _____
_____

Persons/Organizations authorized to receive the information (list all that apply): _____
_____
_____

Specific description of the Protected Health Information to be used or disclosed, including dates of service, if applicable: _____
_____
_____
_____

Specific reason that the Protected Health Information is needed: _____
_____
_____

II. Important Information About Your Rights

The following statements describe your rights in regard to this authorization:

- You may revoke this authorization at any time prior to its expiration date by providing written notice, however, the revocation will not have any affect on any actions that were taken before the revocation was received.
- You may access and copy the protected health information described in this authorization.
- This authorization is voluntary; you are not required to sign this form in order to receive health care benefits for enrollment, treatment or payment.

III. Signature of Patient (this form must be signed by the actual patient, however, a parent may sign if the patient is a dependent child under the age of 18)

I hereby authorize the use or disclosure of my protected health information as described in this form.

_____ _____
Signature of Patient (or parent) **Date**

This authorization will expire on _____

Please return the completed form to:

WMI Mutual Insurance Company
P.O. Box 572450
Salt Lake City, UT 84157-2450
Fax (801) 263-1189