Golden Rule®
A UnitedHealthcare Company

AUTHORIZATION FOR DISCLOSURE OF PERSONAL INFORMATION (GENERAL)

Return this completed authorization to:
Golden Rule Insurance Company
PO Box 68994
Indianapolis, Indiana 46268-0994

Identification Number:

AUTHORIZATION TO DISCLOSE MEDICAL AND NONMEDICAL INFORMATION

I, _____, hereby authorize **Golden Rule Insurance Company (GRIC)**
(please print)
to disclose my personal information as described below.

Description of Information to Be Disclosed (please check all that apply):

- ❑ Medical Information (including claims information)
- ❑ All Nonmedical Information (including financial information)
- ❑ Both Medical and Nonmedical Information (in the event that all boxes are left unchecked, both medical and nonmedical information will be disclosed.)

Purpose: At the request of the individual

Person or Business Authorized to Receive Information:

Name: _____

Address: _____

City, State, ZIP _____

Expiration of Authorization:

This authorization will expire 24 months from the date of your signature. (Only valid for 12 months in Connecticut, Georgia, Illinois, Massachusetts, Minnesota, North Carolina, New Jersey, Ohio, and Oregon.)

Your Signature:

_____ _____
Signature Date

YOUR RIGHTS

- I understand that I may revoke this authorization at any time prior to its expiration date by notifying Golden Rule Insurance Company in writing, but the revocation will not have any effect on any actions taken in reliance on this authorization or relating to the use or disclosure of the protected health information that the entity took before it received the revocation.
- I am not required to sign this authorization to become eligible for coverage or to receive my health care benefits.
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by the federal privacy law regulating health insurers (45 CFR Parts 160 and 164 et seq.).
- I am entitled to a copy of this authorization form.

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