SISCO

MEMBER'S AUTHORIZATION TO RELEASE INFORMATION

I, _____, am a Member of ISO Student Health Insurance administered by SISCO Benefits (SISCO). My Member ID number is _____ and my phone number is (____) ____-_____.

I hereby authorize SISCO to release medical claim information described below to the following Recipient(s):

Recipient Name(s): _____
Recipient Phone number(s): _____

Please release my information pertaining to (**MUST SELECT ONE**):

1. ☐ any enrollment, claims status or payment information SISCO has in its records.

If you are authorizing SISCO to disclose information beyond claims status or payment concerning treatment for one of the conditions described below, you MUST initial the specific category you are authorizing us to disclose. SISCO will not disclose such information unless you provide your initials next to the protected category to indicate YES, that you authorize us to release/disclose information to Recipient(s).

Category	Initial		Category	Initial
Abortion			Alcohol/Substance Abuse	
Reproductive Health			Behavioral Health	
AIDS/ARC			Physical Abuse	
HIV			Domestic Violence	
Communicable Disease (venereal disease)			Genetic Testing	

-OR-

2. ☐ the following specific claim (please describe the claim as accurately as possible, including dates, location of treatment, etc.):
_____
_____
_____

TERMS OF THIS AUTHORIZATION

1. I understand that SISCO will not condition my treatment, enrollment, or eligibility for benefits under a plan, on my signing this authorization.
2. I understand that SISCO will release my information as directed by the terms and conditions of this Authorization.
3. I understand that any information released under this Authorization is out of SISCO's control once sent, and SISCO has no further control over the security or use of this information.
4. I understand I have a right to receive a copy of this Authorization.
5. I understand I have a right to revoke this Authorization, but that the revocation will not apply to international already released under this Authorization.
6. This authorization shall be valid until _____, 20___. (if no date is included, Authorization shall be valid for a period of two years from date of receipt by SISCO).

I have read and understand the terms of this Authorization and hereby authorize the release of the information described above, to the recipient(s) identified above.

This Authorization to Release Information form must be signed below:

Member Signature	**Member's Printed Name**	**Date**

☐ I am a parent or legal guardian of a minor member (Relationship: _____) *
☐ I am the legally authorized representative of the member (Form of authority: _____) *

*Additional verification may be required.

Please send response to:
SISCO Benefits | PO Box 3190 | Dubuque IA 52004-3190
Email: ISOservice@siscobenefits.com
Phone: (833) 577-2586 or Fax: (563) 557-3398

Internal Use Only

Date Entered: _____ Entered By: _____