Authorization to Receive Information (HIPAA)

Introduction

Use this form to authorize individuals to whom John Hancock may disclose information regarding your Long-Term Care policy. ***This authorization is intended to comply with HIPAA.*** HIPAA stands for Healthy Insurance Portability and Accountability Act of 1996 as amended. Under the Health Insurance Portability and Accountability Act (HIPAA) you have the right to receive a copy of your Protected Health Information (PHI) held by John Hancock and authorize that a copy be directly disclosed to another individual or entity.

Questions about this form?
☎ 1-800-377-7311

To email this form:
LTCForms@jhancock.com

See the end of this document for return instructions

1. Policy Information

Insured's Name: First _____ Middle _____ Last _____

Insured's Address: Street _____ City _____ State _____ Zip _____

Policy Number(s): _____

Home Phone Number: _____ Cell Phone Number: _____

2. Authorized Individuals

John Hancock is authorized to disclose my protected health information, including but not limited to, my enrollment records, health information and policy information about me to the individuals designated below. (You should consider listing your spouse, partner, children, and/or any other family member or friend with whom you may want John Hancock to discuss your policy.)

Print Name: _____ Address: _____

Print Name: _____ Address: _____

Print Name: _____ Address: _____

3. Authorization

- I am Providing written authorization to disclose my protected health information to the designated individuals on this form;
- I am providing written authorization to disclose policy specific information to the designee(s) listed above on an ongoing basis.
- I may revoke this authorization at any time by giving John Hancock written notice.
- If I revoke this authorization, the revocation will not affect any action John Hancock took while this authorization was valid before John Hancock received my written notice of revocation.
- Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy regulations.
- My health information may be re-disclosed and no longer protected by HIPAA if the person receiving my health information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as insurers and health care providers. However, John Hancock does require its agents and service providers to protect the confidentiality of health information.
- A copy of this Authorization is as valid as the original.
- I will receive a copy of the Authorization.
- This Authorization expires when coverage under my long-term care insurance policy terminates.

Please Note: If you are the personal representative for the insured, you must attach copies of your authorization, such as a power of attorney, or guardianship papers.

SIGN HERE _____ Insured's Signature (Or Legal Representative)

_____ Today's Date (MM/DD/YYYY)

Submission Instructions

To mail this form:
John Hancock Financial Services
PO Box 55978
Boston, MA 02205

To email this form:
LTCForms@jhancock.com

To fax this form:
1-617-572-6010

Need more information? Call:
Monday through Friday
8:00 A.M. to 6:00 P.M. Eastern Time
John Hancock Long-Term Care: 1-800-377-7311
TTD Hearing/Speech Impaired: 1-800-832-5282