BRADLEY University

Claim Number: _____

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:

1) Person(s) or group(s) of persons authorized to use or disclose the information: Any physicians, medical practitioners, hospitals, clinics, HMO, long-term care facilities, medical or medically-related facilities, pharmacies, insurance companies, Plan Sponsor/Administrator and insurance support organizations such as the Medical Information Bureau.

2) Person(s) or group(s) of persons authorized to collect or otherwise receive the information: The particular Company in the Liberty Mutual Group to which I am submitting a claim and its authorized representatives, including organizations providing claims management services.

3) Description of the information that may be used or disclosed: This Authorization specifically includes the release of all information related to my physical and mental health and my insurance policies and claims, including, but not limited to, those containing diagnosis, treatments, prognosis, prescription drug information, alcohol or drug abuse or information regarding communicable or infectious conditions, such as HIV/AIDS.

4) The information will be used or disclosed only for the following purpose(s): For purposes of investigating, evaluating and processing my claim.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Company in the Liberty Mutual Group to which I have submitted a claim will not be released by the Company to any person or organization except reinsuring companies, or other companies in the Liberty Mutual Group to which I submit a claim for benefits, other persons or organizations performing a business or legal service in connection with my claim, or as may be otherwise permitted or required by law. However, I also understand that, upon disclosure pursuant to this authorization to any person or organization that is not covered by federal privacy regulations, the disclosed information may no longer be protected by those regulations.

- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization, or to the extent that other law provides the Company with the right to contest a claim, by sending a written revocation to the Company in the Liberty Mutual Group to which I have submitted a claim. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and health care operations.

- I understand that authorizing the disclosure of this health information is voluntary and the provision of health care services to me is not conditioned on whether I sign this authorization.

- This authorization will expire 24 months from the date signed.

- I am entitled to a copy of this authorization and acknowledge receipt of a copy thereof.

Name of Individual/Personal Representative:_____
Signature:_____
Description of Authority of Personal Representative:_____
Effective Date: _____

A copy of this authorization will be considered as valid as the original.