

**HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**Insured:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (“My Providers”) to disclose my entire medical record, medications prescribed and any other protected health information concerning me to **Oxford Life Insurance Company or its representatives**. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical records without restriction.

This protected health information is to be disclosed under this Authorization so that **Oxford Life Insurance Company** may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with **Oxford Life Insurance Company**.

This authorization shall remain in force for 36 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that **Oxford Life Insurance Company** may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Release all medical records to: Elite Sales Processing, Inc. (ESP) – PO Box 159 – Avoca, Iowa 51521 – Phone: 712-343-2367 – authorized representative of **Oxford Life Insurance Company**.

\_\_\_\_\_  
Signature of Proposed Insured or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative’s Authority or Relationship to Proposed Insured/Patient