



**AUTHORIZATION TO OBTAIN AND DISCLOSE
PERSONAL HEALTH-RELATED INFORMATION**
This authorization complies with HIPAA Privacy Rule

I hereby authorize any physician, medical practitioner, health care professional, hospital, clinic, laboratory, pharmacy, pharmacist, druggist, medical facility, VA facility, social security administrator, any other health care provider, employer, insurance company, union welfare fund, public or private agency, consumer reporting agency, worker’s compensation carrier, and any other person or organization that has provided payment, treatment or services to me or on behalf of (“My Providers”) to give any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims to North American Insurance Company and any and all affiliates and subsidiaries, their agents, employees, representatives and any persons providing services to them.

The information referenced above includes, but is not limited to, information relating to any medical consultations, treatments or surgeries, diagnoses, prognoses, hospital confinements for physical and mental conditions, use of drugs or alcohol, and communicable diseases, including sexually transmitted diseases, HIV or AIDS. NOTE: (psychotherapy notes does not include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnoses, functional status, treatment plans, symptoms, prognoses, and progress to date.)

I hereby acknowledge that the information released will be used and disclosed so the Company may: 1) administer claims and determine or fulfill any coverage obligations and provide applicable benefits; and 2) conduct legally permissible activities relating to any coverage I have or have applied for with the Company.

I understand all or part of the information collected may be disclosed to any other insurance company with which the Company does business, and any other insurance company with which the insured may have insurance. Information may also be disclosed to persons performing business or legal functions for the Company. The Company may also disclose information to prevent fraud or misrepresentations or when required by subpoena or by court or government order.

This authorization shall remain in full force and effect for twenty-four (24) months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand I have the right to revoke this authorization at any time by sending a written revocation request to North American Insurance Company, 2721 N. Central Ave., Phoenix, AZ 85004. I understand a revocation is not effective to the extent any of My Providers has relied on this authorization or to the extent the Company has a legal right to contest any claim under an insurance certificate or to contest the certificate itself. I understand that any information disclosed pursuant to this authorization may be redisclosed and no longer covered by the federal rules governing privacy and confidential health information, especially to the extent that any information is disclosed in connection with a credit insurance or debt protection product.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization, and I instruct My Providers to release and disclose any requested information without restriction. I acknowledge that if I refuse to sign this authorization, or if coverage has been issued, North American Insurance Company may not be able to provide benefits. I acknowledge that I will receive a copy of this authorization upon my request.

Signature of Claimant

Signed This Date

Signature of Personal Representative’s authority/relationship to Claimant