



HIPAA Authorization
for Release of Health
Related Information

This authorization complies with the HIPAA Privacy Rule

Name(s) of Primary Proposed Insured/patient

Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB Group, Inc. or any of its members or affiliates), or other health care provider that has provided payment, treatment or services to me or on my behalf (collectively, "My Providers") to disclose the entire medical record and any other protected health information concerning me to the company referenced on this authorization ("the Company") and their Producers, employees, and 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 My Providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under the authorization at my request, as permitted by § 164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule").

This authorization shall remain in force for 24 months following the date of my signature below, regardless of my condition and whether living or deceased, 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 sending a written request for revocation to the Company addressed, **Attention: Policyholder Service Department, 2721 North Central Avenue, Phoenix, AZ 85004**. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record the 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 acknowledge that I have received a copy of this authorization.

Signature of Primary Proposed Insured/Personal Representative

Date

If signed by an individual's Personal Representative, describe authority to sign on behalf of the individual:

Power of Attorney Other (please describe): _____

Proposed Insured Policy or contract number (If known): _____