AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This authorization complies with the HIPAA Privacy Rule

NAME OF DECEASED INSURED	INSURED'S DATE OF BIRTH
NAME OF PERSONAL REPRESENTATIVE SIGNING THIS AUTHORIZATION	
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY OR RELATIONSHIP TO THE INSURED	

I am the next of kin or the executor/administrator of the estate of the deceased insured listed above (the "Insured"). 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. ("MIB") or any of its members or affiliates), or other health care provider that has provided payment, treatment or services to the Insured or on the Insured's behalf (collectively, the "Providers") to disclose the entire medical record and any other protected health information concerning the Insured to Oxford Life Insurance Company ("Oxford Life®") and its 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 the Insured made to restrict the Insured's protected health information do not apply to this authorization and I instruct the Providers to release and disclose the entire medical record without restriction for use in determining eligibility for benefits under the Insured's insurance policy or policies.

This protected health information can 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 will remain in force for 24 months, 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 Oxford Life ***(Attention: Privacy Officer, 2721 North Central Avenue, Phoenix, AZ 85004).*** I understand that a revocation is not effective to the extent that any of the Providers has relied on this authorization or to the extent that Oxford Life 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, Oxford Life 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 if I refuse to sign this authorization, Oxford Life may not be able to evaluate any claim for benefits. I acknowledge receipt of a copy of this authorization.

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Signature of Insured's Personal Representative

____
Date Signed

Oxford Life Mailing Address and Contact Information	
Regular or Overnight Mail	2721 North Central Avenue, Phoenix, Arizona 85004
Fax	(877) 584-2777
Email	LifeClaims@oxfordlife.com
Policyholder Services	(866) 641-9999
Website	www.oxfordlife.com

Oxford Life copy – submit with claim form

HIPAA-LC-OLIC (rev. 09/14)

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Signature of Insured's Personal Representative Date Signed

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Fax	(877) 584-2777
Email	LifeClaims@oxfordlife.com
Policyholder Services	(866) 641-9999
Website	www.oxfordlife.com

personal representative copy – keep for your records