

HIPAA Authorization

I hereby authorize **Insurance Resources** and its staff, affiliated companies and/or entities, insurance companies and their re-insurances, to possess, obtain and/or re-disclose my existing personal financial and health information for the sole purpose of the procurement of life, health, long term care, or other insurance products.

I authorize my health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has payment, treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to my Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. This included 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 terminate any agreements I have made with my Provider to restrict my medical records and my associated HIPPA protected health information and I instruct my providers to release and disclose my entire medical record without restriction. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing my privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of **Insurance Resources**, affiliated insurance companies and their re-insurers.

The records may be transmitted via U.S. regular mail, various overnight mail services and through the use of secured electronic devices.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled receive a copy of the authorization.

I understand that I may write to my Representative to revoke this authorization and that revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, insurance companies may not be able to offer insurance coverage, process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that My Provider may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Proposed Insured's Name _____

Proposed Insured's Signature _____

Agent/Witness _____

Signed and Dated on _____

At _____
(City, State, Zip Code)