# HIPPA Authorization

I hereby authorize **Insurance Solutions Group** and its staff, affiliated companies and/or entities, insurance companies and their re-insurers, 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 any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager 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 and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") concerning me to my Representative and its staff, affiliated companies and/or entities, insurance companies and their reinsurers. This included information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted di9seases. 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 Providers to restrict my medical records and my associated HIPAA 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 medic al 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 applications or prospective applications of Insurance Solutions Group, 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 to receive a copy of the authorization.

I understand that I may write to my Representative to revoke this authorization and that the 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 Providers 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)

# HIPAA COMPLIANT AUTHORIZATION

Patient information

PRINT NAME OF PATIENT_______________________BIRTHDATE__________SS#_____________

Information to be released from: ____________________________________________
Name of designated Facility or Provider

____________________________________________
Address

Information to be sent to: __________________________________________

__________________________________________

___________________________ __________________
City, State, Zip Code Telephone Number

Information to be released:

☐ The most recent five years of pertinent information (Chart notes, labs, x-rays and special tests)

☐ Specific information (please specify): ___________________________________

____________________________________________________________________

Purpose for which disclosure is being made: (Please check one of the following)

☐ Insurance ☐ Attorney ☐ Doctor ☐ Personal

Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric Treatment. I give my specific authorization for these records to be released.

**EXCLUDE** the following information from the records released (please initial):

_______Drug/Alcohol abuse/ treatment & diagnosis _______Sexually Transmitted Disease
_______ HIV/AIDS diagnosis/treatment/testing _______ Mental illness or psychiatric diagnosis/treatment

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, Payment or enrollment). I may revoke this authorization in writing. I understand that once the health Information I have authorized to be disclosed reaches the noted recipient, that person or organization May re-disclose it, at which time it may no longer be protected under privacy laws. A copy of this Authorization is as valid as the original.

**SIGNATURE:**______________________________________ **DATE**____________
(patient, guardian, or authorized representative)
*please provide documents to prove authority to sign on behalf of patient.
This authorization will expire 180 days from the date signed.