



AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION HIPAA COMPLIANT

Name of Proposed Insured/patient (Please type or print) Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, 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, prescription history, medications prescribed, and any other protected health information concerning me to the insurance companies and/or settlement companies named below. 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 physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that the insurance companies and/or settlement companies named below may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the insurance and/or settlement companies named below.

This authorization shall remain in force for 24 months following the date of my signature below, 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 providing written notification to the Office of PenFacs Financial Services, Inc. I understand that a revocation is not effective to the extent that the insurance and/or settlement companies named below have a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the insurance companies and/or settlement companies named below except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization or release my complete medical record, the insurance and/or settlement companies named below may not be able to process my application, or if coverage has been issues may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

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| Advantage Insurance Network | Indianapolis Life | Prudential Life |
| Advanced Settlements, LLC | John Hancock Life | ING/Relia Star Life of NY |
| Allianz | Lincoln Benefit Life | ING/Relia Star of CT |
| American General Life (AIG) | Lincoln Financial | ING Security Life of Denver |
| Ameritas | Massachusetts Mutual | Sun Life Ins. Co. of America |
| ANICO | Metropolitan Life | Sun Life Ins. Co. of Canada |
| AVIVA | MONY-Equitable AXA | The New PenFacs Insurance Agency |
| AVS | New York Life | Transamerica |
| AXA | North American | Travelers Life & Annuity |
| Banner Life Ins. Co. | Old Mutual Financial Network | United of Omaha |
| Columbus Life | The Old Line Life | USFL Ins. Co. (CA only) |
| Coventry First | Phoenix Life | U.S. Financial Life Ins. Co. |
| Credit Suisse | Presidential Life | USG Annuity & Life |
| First Global Financial & Ins. | Principal Financial | Union Central Life |
| Services | Professional Underwriting | West Coast Life |
| General American Life Ins. Co. | Consultants | |
| | Protective Life | |

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Signature of Proposed Insured/Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient

NOTE: This Authorization needs to be signed in addition to the Authorization to Obtain and Disclose Information.
Revised 5/2008

