AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

(NAME OF INSURANCE COMPANY MUST BE INSERTED BEFORE THIS FORM IS USED)

This authorization is intended to comply with the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule. This HIPAA authorization must be fully completed and signed as a condition of applying for insurance with the insurance company named above. Your application may not be accepted without a signed authorization.

This form cannot be used in AZ, IN, MD, ME, MN, NC, NY, VA and VT.

I HEREBY AUTHORIZE THE USE AND/OR DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:

1. **Person(s) or group(s) of persons authorized to disclose the information:**
   Any physicians, medical practitioners, health care professionals, hospitals, clinics, laboratories, long-term care facilities, medical or medically-related facilities, pharmacies, pharmacy benefit managers, insurance companies, reinsurers, insurance support organizations and consumer reporting agencies such as the MIB (Medical Information Bureau) or other individuals having personal information about me.

2. **Person(s) or group(s) of persons authorized to collect or receive and use/disclose the information:**
   The insurance company named above and its authorized representatives, including agents, reinsurers, service providers and other insurance support organizations.

3. **Description of the information that may be used and/or disclosed:**
   This authorization specifically includes the release or disclosure of my entire medical record, medical history and any other physical or mental health information concerning me, without restriction (except psychotherapy notes), including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, other than HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome), whether the information is in electronic or paper form.
   [Please use ACORD 757, HIV Antibody / Antigen Consent and Testing Form, or if applicable, the state specific ACORD 757, if disclosure information about HIV / AIDS status is required.]

4. **The information will be used and/or disclosed only for the following purpose(s):**
   For the purpose of underwriting my application for long term care insurance with the insurance company named above, making rating determinations and, if a policy is issued to service coverage, for evaluating contestability and for the continuation or replacement of the policy. I understand that there may be additional uses and/or disclosures of my health information that are specifically permitted by law without my authorization. For example, we may be obligated to disclose health information to government, regulatory and law enforcement entities.

5. The information to be disclosed includes any portion of my medical records within the past five years I have previously requested be withheld from release, which request I hereby terminate for purposes of this authorization.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGEMENT:

- I understand that health information about me provided to the insurance company named above is protected by federal and state privacy regulations. However, I also understand that, upon disclosure pursuant to this authorization to any person or organization that is not covered by the federal and state privacy regulations, the disclosed information may no longer be protected by those regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization, or to the extent that other law provides the insurance company named above with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the insurance company named above, Underwriting Supervisor, at the address listed above.
- I authorize the insurance company referenced above or its reinsurers to make a brief report of my health information to MIB, Inc.
- This authorization will expire 24 months from the date signed.
- I understand that either I or my authorized representative will receive a copy of this signed authorization.

A copy of this authorization will be considered as valid as the original.

Applicant's Name (Please Print)	Date of Birth (mm/dd/yyyy)
Applicant's Signature	Date (mm/dd/yyyy)

If this authorization is signed by a personal representative of the applicant, a description of the representative's authority to act on behalf of the applicant must be included below: