AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULES

Patient Name: Date of Birth:

SSN:

Name, Address & Phone Number	Reason for Treatment	Date of Last Visit
Primary Care Physician		
All other physicians or hospitals providing treatment in the past 10 years		

This authorization is for the Release of Health-Related Information to Branca-Rampart Agency, Inc.

My Providers are any health plan physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefits manager or other health care provider that has provided payment, treatment or services to me or on my behalf. This includes psychotherapy care. My Protected Health Information is my entire medical record and other health information. It includes information such as: the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases and mental illness; the use of alcohol, drugs, and tobacco; and psychotherapy notes.

I authorize my Providers to disclose my Protected Health Information to the above-named company or person(s); their agents, employees, representatives, and providing facilities.

By signing below: 1) I acknowledge that any agreements I make that restrict my Protected Health Information do not apply to this authorization; and 2) I instruct My Providers to release and disclose my Protected Health Information without restriction.

This Protected Health Information is to be disclosed under this Authorization so that the above named 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 provide coverage and benefits; 4) administer coverage; and 5) conduct other activities that are allowed or required by law and relate to any coverage I have or have applied for with the above named. This authorization shall remain in force for 30 months following the date below. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time by doing so in writing and presenting the written revocation to the above named. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to an insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer protected by the Health Insurance Portability and Accountability Act, but will be protected by other applicable federal and state laws relating to the protection of personal information.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. 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 to release my Protected Health Information, the above named may not be able to assist me in processing my application.

I acknowledge that I have received a copy of this Authorization.

SIGNATURE OF PROPOSED INSURED DATE

(If age 15 or over, otherwise applicant)

AUTHORIZED INSURANCE CARRIERS				
AIG	EQUITABLE	MUTUAL OF OMAHA	PRINCIPAL NATIONAL LIFE	THE STANDARD
ALLIANZ	FIDELITY SECURITY - DI	NATIONAL GUARDIAN LIFE	PROTECTIVE LIFE	TRANSAMERICA LIFE
AMERICAN NATIONAL	GLOBAL ATLANTIC	NATIONAL LIFE	PROTECTIVE LIFE OF NY	UNITED OF OMAHA
AMERITAS	JOHN HANCOCK	NATIONWIDE	PRUDENTIAL	US LIFE OF NY
ASSURITY	JOHN HANCOCK OF NY	NEW YORK LIFE	RAMPART LIFE	WILLIAM PENN OF NY
BANNER	LINCOLN NATIONAL LIFE	NORTH AMERICAN	SBLI	ZURICH
CENTURIAN	LINCOLN LIFE & ANNUITY OF NY	ONE AMERICA	SECURIAN	
CINCINNATTI LIFE	LLOYDS OF LONDON	PACIFIC LIFE	SECURITY MUTUAL LLIFE	
COLUMBUS LIFE	MINNESOTA LIFE	PRINCIPAL LIFE	SYMETRA	