HIPAA Compliant Authorization for Release of Information

(Required)

I (Patient/Insured) _____authorize_____ and/or any licensed physician, healthcare professional, hospital, clinic, laboratory, medical facility, pharmacy benefit manager, insurance company, motor vehicle agency, Medical Information Bureau (MIB), or any other organization, institution or person that has any records or knowledge of me or my health within the past 10 years, including my entire medical records, pharmaceutical records and any other information protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to disclose such information, including my entire medical records and any other protected health information concerning me to Comprehensive Insurance Programs, Inc., 513 Centennial Blvd., Voorhees, NJ 08043, as well as the aforementioned life insurance companies and their reinsurers, when necessary, for the purpose of evaluating my insurability. 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 or 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 any physician, healthcare professional, hospital, clinic, medical facility or other healthcare provider to release and disclose my entire medical records without restriction. I understand that upon disclosure to any person or organization that is not a health plan or healthcare provider, the information may no longer be protected by federal privacy regulations.

This authorization shall remain in force for 36 months following the date of my signature below, *and that a photocopy or facsimile of this authorization has the full force and effect as the original.* I understand that I have the right to revoke this authorization in writing, at any time. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that a revocation does not apply to information that has already been released in response to this authorization.

I also acknowledge receipt of the notices required by the Fair Credit Reporting Act, which are printed below this authorization. I have been informed of my right to receive a copy of this authorization. I am aware I may be required to complete another application before coverage can be put into effect.

The Fair Credit Reporting Act Notification

In compliance with the Public Law 90-508 (Fair Credit Reporting Act), I understand that part of the underwriting procedure, any life insurance company may secure on me a routine inquiry involving interviews regarding my character, general reputation, personal characteristics, etc. I further understand that upon written request from me, additional information will be provided concerning the nature and scope of such inquiry, if one is actually made.

Patient/Insured Printed Name: _____DOB:_____

Patient/Insured Signature _____Date: _____

Insurance Company Affiliations

AIG/American General Life Ins
Allianz
AXA Equitable
Banner Life Insurance Co.
Brighthouse Financial
Columbus Life
CPI Companies
Global Atlantic
Guardian
John Hancock
Lafayette Life Insurance Co.
Legal & General America
Lincoln Financial Group
Mass Mutual
MetLife
Minnesota Life
Mutual of Omaha
National Life Group
Nationwide Financial
New York Life
North American Company
Ohio National
Penn Mutual
Principal Life Insurance Co.
Principal National Life Insurance Co.
Protective Life
Prudential Insurance Co.
Safe Harbor
Symetra Life Insurance Co.
Transamerica Life Insurance
VOYA
Welcome Funds
William Penn Life
Zurich Life