Authorization for Release of Personal Health Information

This Authorization complies with the HIPAA Privacy Rule and permits health care providers and other covered entities to disclose personal health information.

_____

Name of Proposed Insured/Patient (Please Print)

DOB: _____ SSN: _____

I authorize _____, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, or coverage to me within the past 10 years to discuss and disclose my entire coverage and medical record(s) to _____, its agents, employees, insurance support organizations, reinsurers, and their representatives. This also includes information on the diagnosis and treatment of mental illness (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs and tobacco. *Statements required by §164.508(c)(1)(ii), (c)(1)(iii).*

I understand my personal coverage and health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by Secura Consultants. Protected health information also includes, but is not limited to: Hospital records, treatment records/office notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, benefit information, claims information, demographic information, and claims payment information. *Statements required by §164.508(c)(1)(i).*

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any insurance company, physician, health care professional, hospital, clinic, medical facility, other health care provider or health plan, or other entity subject to HIPAA to release and disclose my medical record without restriction.

I understand that unless prohibited by state and/or federal law the protected health information is to be disclosed under this authorization so that Secura Consultants may: 1) underwrite my application for coverage, make claim eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; and 3) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the insurance carriers represented by Secura Consultants. *Statements required by §164.508(c)(1)(iv).*

The following groups of persons employed or working for Secura Consultants may use my personal health information which is described above: employees of the underwriting, administration, and any other personnel of Secura Consultants, and its authorized representatives, and business associates that perform functions or services that pertain to any coverage I have, have applied for, or may in the future apply for with insurance carriers whether or not they are represented by Secura Consultants. *Statements required by §164.508(c)(1)(ii).*

I understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure. *Statements required by §164.508(c)(2)(iii).*

This authorization shall remain in force for 12 months following the date of my signature below, and a copy of this authorization is as valid as the original. *Statements required by §164.508(c)(v).*

I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to: Life, LTC and Disability Underwriting, Secura Consultants, 6465 Wayzata Boulevard, Suite 920, Minneapolis, MN 55426. *Statements required by §164.508(c)(2)(i).* Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I Understand that if I refuse to sign this authorization to release my complete medical record, Secura Consultants may not be able to process my application for life, long term care and/or disability coverage. *Statements required by §164.508(c)(2)(ii).* Upon receipt of your signed authorization, a copy will be provided to you. *Statements required by §164.508(c)(4).* Any alteration of this form will not be accepted.

Signature of Insured/Patient _____ Date ___/___/_____