AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME (please list other names used)
DATE OF BIRTH [ ] [ ] [ ]
SOCIAL SECURITY
ADDRESS
CITY, STATE, ZIP
Medical Record # or Kaiser # if Applicable

I Authorize (Name of Health Care Provider/Clinic)_____
(Address)_____
(Phone) _____ to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes) chemical or alcohol dependency, laboratory tests results, medical history, treatment, billing, insurance or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and payment of my health care will not be affected if I do not sign this form.

Date(s) of services: _____ To _____

Reason or Purpose of the use and/or disclosure: Insurance Services

Description of Information to be released:

- ☐ **General Medical Information**
- ☐ **Mental Health**
- ☐ **X-Rays**
- ☐ **Chart Notes**
- ☐ **Laboratory Results**
- ☐ **HIV Test Results**
- ☐ **Alcohol/Drug**
- ☐ **Other**_____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager 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 and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to my Representative and its *staff,* affiliated companies and/or entities, including but not limited to RSA Medical, insurance companies and their re-insurers. 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, my prescription records and history of medication prescribed, but excludes psychotherapy notes.
The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications by *Brokers Insurance,* affiliated insurance companies and their re-insurers. The records may be transmitted via US regular mail, various overnight mail services and through the use of secured electronic devices.

The Health Insurance Information described herein shall be released to:
C/O Global Insurance Solutions
_____ (Insurance Company Name)

_____
Name of Person or Entity (service), Street Address, City , State and Zip Code

By my signature below, I terminate any agreements I have made with my Providers to restrict any medical records and any associated HIPAA pro- tected health information and I instruct my Providers to release and disclose my entire medical records without restriction. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer is covered by certain federal rules governing privacy and confidentiality of health information.

This authorization shall be valid for twelve (12) months from the date of this authorization unless I otherwise specify the date or ban an event or _____ (enter date). A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

_____ [ ] [ ] [ ]
Signature of Patient Or Patient's Representative — Date

_____ _____
Print Name of Patient's Representative — Relationship