

Authorization for Release of Information



For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize **Algren Associates, Inc.**, _____ (the "Representative") and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed at the bottom of this page and to insurance agents and brokers acting on my behalf with respect to obtaining such insurance coverage.

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 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 the Representative and its staff, affiliated companies and/or entities, 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, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. 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 or prospective applications of the insurance companies listed at the bottom of this page and their re-insurers as well as the Representative and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. 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.

I understand that I may write to the Representative to revoke this authorization and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that, to the extent that other law allows an insurance company listed below to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

I understand that if I refuse to sign this authorization, the Representative may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form, or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment or payment for services, or my eligibility for health care benefits; provided, however, that if a health care service (e.g. a physical exam) is requested solely for the purpose of creating protected health information to be disclosed to a third party, the health care provider may refuse to provide the service if I do not sign this authorization.

_____ **Proposed Insured's Name**

_____ **Proposed Insured's Signature**

_____ **Signed and Dated On**

_____ **At (City, State, Zip Code)**

Agent/Witness Signature: _____

Print Agent/Witness Name: _____

Algren Associates, Inc.	ExamOne	Minnesota Life	Pro Scan Partners	United of Omaha
Allianz	Express Imaging Services	Mutual of Omaha	Protective Life & Annuity Company	United States Life
American General	Guardian	Nationwide	Prudential Financial	VOYA
American National	Gen Re	New York Life	ReliaStar Life Insurance Co.	Welcome Funds
Ashar Group, LLC	Genworth Life Insurance Co.	North American Co. for Life & Health	SBLI	William Penn
Axa Equitable	Human API	OneAmerica	Securian	Zurich American Life Ins. Co.
Banner Life	John Hancock	Pacific Life	Security Mutual Life	Other:
Brighthouse	Life Ins. Co. of the Southwest	Penn Mutual	Stonehill Settlements	
Cincinnati Life	Lincoln National Life Ins. Co.	Principal Life Insurance	Symetra	
Coventry Financial	Mass Mutual	Principal National Life Insurance	Transamerica Life Insurance Co	