HIPAA Compliant Authorization To Release Confidential Medical Information

Records and Information obtained will be disclosed to SPJST Fraternal Life Insurance, PO Box 100, Temple, TX 76503; ATTN: Underwriting

I authorize any and all medical practitioners, physicians, pharmacists, pharmacy benefits managers, hospitals, clinics, nurses, or records custodians, other insurers to which the proposed insured has applied or may apply, reinsurers, or other medically related facilities, health clearing houses, MIB, LLC, or persons who perform business, professional, or insurance tasks for them, consumer reporting agency; to release

Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKG's.

to

SPJST Fraternal Life Insurance.

The purpose of this disclosure is to evaluate my application for insurance. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. **Complete medical records are to be disclosed.**

Applicants Name:_____
First Middle Last

Other Names Used: (Maiden) _____

Date of Birth: _____

Covering the period of health care from: _____to _____

I understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may become subject to further disclosure by the insurance company. For example, the insurance company may be required to provide it to MIB LLC, an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization (HIPAA 1996). This Authorization will expire in six (6) months from my date of signature below. I understand I may revoke this Authorization at any time by requesting in writing to SPJST at the address listed above. A photocopy of this original will be treated in the same manner as the original.
I understand that if I refuse to sign this authorization to release my complete medical records, SPJST will be unable to gather information needed to determine making an eligibility, underwriting and risk rating decision.
I authorize SPJST Fraternal Life Insurance, or its reinsurers, to make a brief report of my personal health information to MIB, LLC.

*HIPAA provides an exception to this for the purposes of underwriting that insurance companies may condition insurance enrollment or eligibility on whether the individual signs the authorization.

Signature of Applicant:_____ Date:_____

Or Parent if the applicant is a minor:_____ Relationship:_____