Authorization to Obtain and Disclose Information

This authorization complies with HIPPA, HITECH, and GLBA privacy regulations.

I understand that the life insurance companies named below, their reinsurers, and insurance support organizations, my independent insurance representatives, and those persons and employees authorized to represent them, including those persons defined as "business associates" under the HITECH Act, may need to collect information on me in regard to proposed coverage.

21st Century Insurance, Accordia Life, AIG/American General, Allianz Life, American National, Apps, Assurity, Athene Annuity & Life, AVS, AXA Equitable, Banner Life, Brighthouse Financial, Brown, Brown & Gomberg, Cincinatti Life, Companion Life of NY, Coventry, EMSI, Exam One, Express Imaging Services, Fidelity & Guaranty, Fidelity Security Life, Foresters, Forethought Life Insurance Co., Genworth Life, Great American, Illinois Mutual, John Hancock USA, Kemper, Lafayette Life, Life Insurance Co. of the Southwest, Lawrence Brown, Lincoln National Life, Mass Mutual, Metlife Investors, Midland National, Minnesota Life, Mutual of Omaha, National Life Group, Nationwide, New York Life, North American, One America, Pacific Life, Penn Mutual, Peterson International, Portamedic, Principal National Insurance Co., Protective Life, Pruco Life Insurance Co., SBLI, Standard Life Insurance Co., Superior Mobile Medics, Symetra, Transamerica, United of Omaha, The Cohen Agency, VOYA, Welcome Funds, William Penn of NY, Zurich

Other:_____ **Insured Initials:**_____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf and any insurer, reinsurer, insurance support organization, financial source, and employer to disclose the types of information listed below when this authorization is presented. I authorize all said sources listed above, except the Bureau, to give such records or knowledge to Agency Services of Arkansas, DBA The ASA Group. I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected. This information includes my entire medical record and any other Protected Health Information concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This includes information on the diagnosis and treatment of mental illness, and the use of alcohol, drugs, and tobacco.

This also includes information on other insurance coverage, hazardous activities, character, general reputation, mode of living, finances, vocation, and other personal traits. This also includes genetic information about me or my family members. By signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical file without restriction.

My Protected Health Information is to be disclosed under this authorization so that the insurance companies named above and their reinsurers may: 1) determine my insurability and underwrite my application for coverage by making eligibility, risk rating, and policy issuance determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the insurance companies named above. Those parties name above may disclose the information that they have collected.

They may disclose this information to: 1) other insurers to which I have applied or may apply; 2) reinsurers; 3) the Medical Information Bureau; or 4) other persons who perform business, professional, or insurance services for them.This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I acknowledge receipt of this notice and understand that I have the right to revoke this authorization in writing, at any time, by sending written request to Agency Services of Arkansas, DBA The ASA Group at 11807 Hinson Road; Little Rock, AR 72212. I understand that a revocation is not effective if any of My Providers have relied on this authorization or to the extent that any of the insurance companies named above have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

Records to be released to: Agency Services of Arkansas, DBA The ASA Group, 11807 Hinson Rd., Little Rock, AR 72212, P:(501)224-7739 | F:(501)223-3791 | records@theasagroup.com

Signed at:_____ **Date:**_____

Insured's name:_____ **DOB:**_____

Insured's address:_____ **DL#:**_____

_____ **SSN:**_____

Insured's signature:_____ **Date:**_____

Witness signature:_____ **Date:**_____