

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, American General, Allianz Life, American National, Apps, Assurity, Athene Annuity & Life, AVS, AXA Equitable, Banner Life, Brighthouse Financial, Brown, Brown & Gombert, 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, 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 physician, health plan, medical practitioner, medical care provider, psychologist, chiropractor, physical therapist, hospital, nursing home, mental health facility, rehabilitation or ambulatory care center, medical clinic, laboratory, pharmacy, Pharmacy Benefit Manager, treatment facility, insurer, insurance support organization, service provider, Kaiser Permanente, financial institution, consumer credit reporting agency, certified public accountants and tax preparers, educational institution, Federal, State, or Local Governmental Agency, including the Social Security Administration, Veterans Administration, or Workers Compensation Board, an authorized medical officer of a United States Government facility, law enforcement agencies, state and local tax agencies, or other medical or medically related facility, specifically including those persons/organizations listed above, to give or disclose my entire medical record and any other protected health information, or other personal, private, or privileged information concerning me for the past 10 years to Agency Services of Arkansas, DBA The ASA Group, its agents, employees, vendors or representatives. I authorize the disclosure of any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition are to be released, including information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, ARC (Aids-Related Complex) or AIDS, and sexually transmitted diseases; genetic information and genetic testing results; and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco; employment information and history, including job duties, earnings, personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits, finances, tax records, and bank records; business transactions including billing, invoice, and payment records; academic transcripts; law enforcement, court and military records; and information concerning Social Security benefits, or other disability or workers' compensation benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. Such information shall be referred to herein collectively as "My Information". My Information is to be disclosed under this authorization so that the insurance companies named above and their reinsurers may: 1) underwrite my application for coverage, make 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. I understand and acknowledge that any agreements I have made to restrict My Information, including protected health information, do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider, or other entity to release and disclose My Information, including my entire medical record, without restriction. This authorization will be valid for two (2) years or a lesser time limit as required by applicable law in the jurisdiction in which any policy is issued. I understand that I have the right to refuse to sign or to revoke this authorization in writing, at any time, by sending a written request for revocation to The ASA Group, 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 the Company has taken action in reliance on this Authorization or has 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. I understand that if I refuse to sign, alter, or revoke this Authorization the Company may not be able to process my application and it may be a basis for denying my request for coverage, or if coverage has been issued may not be able to make any benefit payments. I understand and acknowledge that I will receive or have received a copy of this authorization. I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

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: