



**AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION**

Applicant / Primary Insured Name

Policy / Certificate # (if applicable)

Phone #

Address (Street, City, State, Zip)

Protected Health Information (PHI) to be Used and/or Disclosed: Any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C (AIDS-related complex).

Entities or Persons Authorized to Use or Disclose: U.S. Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other health care professional, hospital or other health care facility, counselor, therapist or any other medical or medically related facility or professional.

Entities or Persons Authorized to Receive: Philadelphia American Life Insurance Company (PALIC) or its agents, employees, designees, or representatives, including my PALIC agent or broker.

Purpose of this Authorization:

By signing this form, you will authorize PALIC to use and/or disclose your Protected Health Information (PHI) to determine if your application will be approved for health insurance or that you are eligible for benefits. This authorization is a condition of your approved application for our health insurance or your eligibility for benefits.

You also will authorize PALIC to obtain your Protected Health Information (PHI) from other covered entities so that we may determine payment of a claim for specified benefits involving you.

Effect of Declining:

If you decide not to sign this authorization, we may decline to approve your application for health insurance or to provide benefits.

This authorization is a condition of our paying the claim. If you decide not to sign this authorization, we may decline to pay the claim.

Effect of Granting this Authorization: The PHI to be used and/or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

Expiration: This authorization will expire upon the termination of any PALIC coverage that may be in effect.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to: Philadelphia American Life Insurance Company, P.O. Box 4884, Houston, TX. 77210-4884

I understand that revocation of this authorization will not effect any action PALIC took in reliance on this authorization before PALIC received my written notice of revocation.

I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this authorization, I am confirming my authorization of the use and/or disclosure of my Protected Health Information, as described in this authorization.

Print Name

Signature

Date

If this authorization is signed by a personal representative, on behalf of the individual, complete the following:

Personal Representative: Print Name

Please indicate Representatives relationship to Applicant/Insured and briefly describe Representatives authority to act for Applicant/Insured.

Signature

Date

A photocopy of this authorization is as valid as the original, and I and my PALIC agent or broker are entitled to receive a copy of this form. **YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.**