AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION TO INSURANCE BENEFIT SYSTEM ADMINISTRATORS

P.O. BOX 2943 Shawnee Mission, Kansas 66201-1343 FAX: 913-901-0534

Name of Insured (please print) Date of Birth Certificate Number

Name of Insured Spouse (please print) Date of Birth

Insured Children and Dates of Birth (please print):

NAME	DOB	NAME	DOB

I authorize the following THIRD PARTY:_____, and his/her/its agents, employees and representatives (together hereinafter referred to as Information Recipient), to receive all non-public personal information and individually identifiable protected health information (Protected Information) concerning the above named insured person(s) (Insured Person(s)) as may appear in documentation or information maintained by Allied National, LLC (Allied) on behalf of the Insured Person(s), including but not limited to applications for coverage, insurance claims, explanations of benefits, billings or fee statements from medical providers, medical records from medical providers and all other documentation or information maintained by Allied and containing Protected Information of the Insured Person(s). **This authorization specifically allows disclosure of documentation and information relating to physical and mental conditions of the Insured Person(s), including diagnosis and treatment of those conditions by medical providers.** *This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.*

By my signature below, I acknowledge that any other agreements made by the Insured Person(s) to restrict the Protected Information do not apply if in conflict with this authorization.

The purpose(s) of disclosing the Protected Information to Information Recipient under this Authorization is _____.

This authorization shall remain in force with respect to an Insured Person for six (6) months from the respective date stated below, or until revoked in writing by that Insured Person, whichever occurs first. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time. I understand that a revocation is not effective to the extent that Information Recipient has irrevocably relied upon this Authorization. I understand that any documentation or information that is disclosed pursuant to this authorization may be re-disclosed and may then be no longer covered by federal or state law governing privacy and confidentiality of personal and health information. I acknowledge that I am the person and have the authority, as stated below.

I understand that if I refuse to sign this authorization, Information Recipient may not be able to obtain my Protected Information. I acknowledge that a copy of this authorization will be provided to me upon request.

Signature of Insured
[or His/Her Legal Representative]
[or if under age 18, His/Her Parent] Date

Signature of Insured Spouse
[or His/Her Legal Representative] Date

Description of Legal Representative's Authority (please indicate which Insured Person(s) is/are represented)

Signature of Insured Child(ren) (if age 18 or older) Date