# HIPAA Authorization for Release of Medical Information

| INSURER |
| --- |
| OM Financial Life Insurance Company |

Name of Proposed Insured (please print or type) _____ Date of Birth _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, medications prescribed and any other protected health information concerning me to OM Financial Life. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical records without restriction.

This protected health information is to be disclosed under this Authorization so that OM Financial Life may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment 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 OM Financial Life.

This authorization shall remain in force for 36 months following the date of my signature below, and 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, by providing written notification to the entity identified above, I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that OM Financial Life 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 is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by OM Financial Life except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical records, OM Financial Life may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Release all medical records to MID-AMERICA AGENCY SERVICES, INC. (MAAS), 1205 7TH STREET, HARLAN, IOWA 51537 (712-755-2700) authorized representative for OM Financial Life.

**Signature of Proposed Insured or Personal Representative** _____ **Date** _____

**Description of Personal Representative's Authority or Relationship to Patient** _____