HIPAA - AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

I ________________________________ (Proposed Insured/Patient) ________________ (Date of Birth) hereby authorize any and all individually identifiable health information, including medical records, reports, pharmaceutical records, drugs, diagnostic testing, lab work, and specific language authorizing sensitive condition data pertaining to mental health, substance or alcohol use and STDs.

1. I understand that the following parties may need to collect information on me regarding the proposed coverage: Serb National Federation and its reinsurers; any insurance support organization; any consumer reporting agency; and all persons authorized to represent these organizations for this purpose.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, or medically related facility, the Medical Information Bureau ('MIB') or other organization, institution or person that has knowledge or records of me and my health to disclose information as allowed or required by law.
3. I understand that this authorization is needed for the purpose of gathering information for making eligibility, underwriting and risk rating determinations.
4. Unless revoked earlier, this authorization will be valid for twenty-four (24) months after the date it is signed.
5. I understand that I can revoke this authorization at any time by giving written notice to the Insurance Company named above at the address shown above. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.
7. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.
8. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV).
9. Signature cannot be signed by anyone under age 18 years – must be signed by parent or guardian. Cannot be signed by spouse unless Power of Attorney.

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Signature of Proposed Insured or Other Authorized Person Date

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Signature of Person authorized on behalf of Proposed Insured Date