HIPAA AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION

Purpose of Authorization:
The purpose of this authorization is to determine my eligibility for **LIFE INSURANCE PRODUCTS** or related services or conduct other legally permissible activities that relate to any insurance company or service provider listed below.

HIPAA Authorization:
I hereby authorize any licensed physician, medical practitioner, consulting physician, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, pharmacy related service organization or other medically related facility, insurance company, The Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health to disclose any and all such information regarding diagnosis, treatment, prognosis and consultations to the life insurance companies and servicing agencies listed on this form along with their reinsurers or providers at the time of my signature. Furthermore, I authorize the release of privileged information such as but not limited to alcohol and/or drug treatment, HIV/AIDS treatment and psychiatric records. Treatment, payment, enrollment in a health plan or eligibility for health insurance benefits may not be conditioned on my signing this authorization. To facilitate rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency utilized by the insurance company to collect and transmit such information. I acknowledge that the information to be disclosed may be protected under State and Federal privacy laws and regulations. A photocopy of this authorization shall be as valid as the original. I have received a copy of the Fair Credit Reporting Act Notification and the Exchange of Information (MIB) disclosure. I understand that I may receive a copy of this authorization. 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.

Life Insurance Companies, Servicing Agencies and Writing Agents authorized to receive/transmit information under HIPAA guidelines are: AgencyONE, Allianz, American General Life Insurance/U.S. Life, American National/ANICO, APPS, Arbor Group, Ashar Group, LLC, AXA Equitable/MONY, Banner Life/William Penn, Brighthouse Financial, Cincinnati Life, Coventry, EMSI, Evergreen Settlements,ExamOne, Exceptional Risk Advisors, LLC, Express Imaging Services, Fortamus, Gen Re, Global Atlantic Financial Group, Guardian, Habersham Funding, LLC, IMG Paramed, Inc., Jet Stream, John Hancock, LifeMark Partners, Lincoln Financial Group, Lloyd's of London, LTCI Partners, Mass Mutual, Minnesota Life/Securian Life, Nationwide, New York Life, North American, Ohio National, OneAmerica, Pacific Life Insurance Company, Pacific Life & Annuity Company, Pan-American Assurance Company, Penn Mutual, Principal Life Insurance Co, Principal National Life Insurance Co, Protective Life Brokerage, Protective Life & Annuity, Prudential, Reliastar Life Insurance Company, Reliastar Life Insurance Company of NY, SBLI, Security Life of Denver Insurance Company, Security Mutual Life, Symetra, Transamerica, United of Omaha, Mutual of Omaha, Voya Financial, Welcome Funds, Inc., Zurich Life, Zurich American Life Insurance Company.
*** My writing agent, ______________________________, and his/her agency, ____________________________, are also authorized to receive or transmit information under HIPAA guidelines.**

I, the undersigned, hereby authorize any and all medical practitioners, physicians, hospitals, clinics and custodians or anyone else located at:

Medical Facility: ____
Facility Address: ____
Date of Services: ____
Contact Person: ____

To release records and information regarding the Proposed Insured listed below to and exchanged between the parties listed above and:

AgencyONE
11200 Rockville Pike, Suite 500
Rockville, MD 20852
Phone: 301.803.7500
Contact Person: ____

Duration:
Unless otherwise revoked, I agree this authorization shall remain valid for the lifetime of the undersigned, absent any provisions of any applicable state statute or regulations to the contrary, in which event it shall remain valid for 24 months or the maximum period permitted there under. I understand that I may revoke my authorization at any time by submitting in writing request of revocation to: AgencyONE, Chief Underwriter, 11200 Rockville Pike, Suite 500, Rockville, MD 20852. However, any action taken in reliance on this authorization prior to the notice of revocation shall be valid.

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Proposed Insured **PRINT**	Proposed Insured **DOB**	Proposed Insured **SIGNATURE**	**DATE**