



## FINANCIAL AND MEDICAL RECORDS AUTHORIZATION

**(This authorization complies with the HIPAA Privacy Rule)**

***Give completed and signed copy to Proposed Insured***

Name of Proposed Insured/Patient (please print) \_\_\_\_\_

Date of Birth \_\_\_\_\_ S.S.# \_\_\_\_\_

Name of Additional Proposed Insured/Patient (please print) \_\_\_\_\_

Date of Birth \_\_\_\_\_ S.S.# \_\_\_\_\_

I authorize Belman Klein Associates, Ltd. the agent/broker named below, Insurance support organizations (such as MIB, Inc), the companies listed at the bottom and their reinsurers, agents employees and representatives to obtain medical and other information. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider, insurance company, the Medical Information Bureau, Inc., employer, consumer reporting agency, or other organization, institution or person that has information available as to my employment or other Insurance coverage, or has provided payment, medical care, treatment, supplies, advice or services to me or on my behalf within the past 10 years ("My Providers") to disclose such information, including my entire medical record and any other protected health information concerning me to the individuals/entities named above. 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 My Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization at my request, as permitted by §164.508(c)(1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

My protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage by making eligibility, risk rating, policy/certificate 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 the Company(s).

This authorization shall remain in force for 24 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 sending a written request for revocation to Belman Klein Associates, Ltd., 5560 Sterrett Place, Suite 200, Columbia, MD 21044, Attention: HIPAA Privacy Official. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective to the extent that any of My Providers have relied on this authorization or to the extent that the companies listed below have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as HIPAA Privacy Rule).

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, my application may not be processed, or if coverage has been issued benefit payments may not be made. I acknowledge that I have read and received a copy of this authorization.

\_\_\_\_\_  
Signature of Proposed Insured/Patient or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Additional Proposed Insured/Patient or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

If this authorization has been signed by a personal representative of the proposed insured/patient, please describe the basis for the personal representative's authority to act on behalf of the proposed insured/patient: \_\_\_\_\_

Name of Agent/Broker \_\_\_\_\_ S.S.# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Companies to Which This Authorization Applies:**