

# AUTHORIZATION TO RELEASE INFORMATION

This authorization is HIPAA compliant

Proposed Insured \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

**Purpose:** The purpose of this Authorization is to permit Brokerhouse Insurance, Leaders Financial, First Heartland Corporation (FHC) or Transition Planning to obtain and release non-public personal information about me, the Proposed Insured named above, for the purposes of determining my eligibility for and obtaining insurance products and services from one or more of the insurers or other institutions ("the Companies") listed below. Information that may be released to and disclosed by Brokerhouse Insurance, Leaders Financial, First Heartland Corporation (FHC) or Transition Planning and the Companies listed below pursuant to this Authorization shall include any and all information, to the extent permitted by law.

**Information to be Released:** The information to be released pursuant to this Authorization includes any personal health information, records, or data concerning my past, present or future mental, physical or behavioral health or condition ("Information"), to the extent permitted by law. Information includes all information, records or data relating to my: physical or mental history or condition; medical treatment, diagnosis, or prognosis, including medication prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances; occupation; avocation, including any hazardous hobbies; driving records; aviation activities and other personal traits. I understand that Information may also include results from blood, saliva, urine and other tests.

I further understand that Information may, if applicable, include information regarding diagnosis, prognosis and treatment of: alcohol or drug abuse (including records protected under federal law 42 CFR Part 2); serious communicable disease or infection, including sexually transmitted diseases; HIV infection, including medical tests results.

**Authorization:** I authorize any physician or other medical practitioner, any hospital, clinic, or other health-related facility, any medical testing laboratory, any insurer, any state motor vehicle department, my past or current employer(s), the Social Security Administration, and any other organization, institution or person that has Information about me to release such information to Brokerhouse Insurance, Leaders Financial or Transition Planning and its authorized representatives.

I specifically authorize the Companies listed below to receive Information from and to release Information to Brokerhouse Insurance, Leaders Financial, First Heartland Corporation (FHC) or Transition Planning. I also specifically authorize Brokerhouse Insurance, Leaders Financial, First Heartland (FHC) or Transition Planning and the Companies listed below to release or redisclose Information about me to their reinsurers, underwriters or any other persons or organizations performing business, professional or insurance functions for them. I also authorize the Medical Information Bureau, Inc. (MIB) to relate Information directly to any Company listed below upon such insurer's request, provided the insurer is a member of MIB.\*

I understand that Information disclosed to Brokerhouse Insurance, Leaders Financial, First Heartland Corporation (FHC) or Transition Planning may no longer be subject to state and federal privacy laws and regulations and may be subject to redisclosure. I understand that if I refuse to sign this Authorization to release my complete medical records, Brokerhouse Insurance, Leaders Financial, First Heartland Corporation (FHC) or Transition Planning or the Companies may not be able to process my request.

I also authorize my Agent, named below, to receive Information and I authorize Brokerhouse Insurance, Leaders Financial, First Heartland Corporation (FHC) or Transition Planning to disclose such Information to my Agent, to assist in the purpose of this Authorization to the extent permitted by law.

A photocopy of this Authorization shall be valid as the original.

This Authorization shall be effective for two (2) years after the date signed below, unless revoked by me in writing and written notice of the revocation is provided to Transition Planning at 8841 Helena Road, Pelham, AL 35124.

Accordia Life	First Heartland	Minnesota Life	Pruco Life Ins. Co.
Allianz Life Ins. Co.	Genworth Life Ins. Co.	Mutual of Omaha	Security Mutual
American General Life	ING Life & Annuity	Nationwide	Symetra
American National Ins.	ING Security Life of Denver	North American Life & Health	Transamerica
Ameritas	John Hancock Life Ins. Co.	Pacific Life	United of Omaha
Amerus	Lincoln Life	Penn Mutual	Union Central
Assurity Life	Lloyd's of London	Principal Life Ins. Co.	Zurich American
AXA Equitable Life	MetLife Investors USA	Protective Life	
Banner Life	Metropolitan Life Ins. Co.	Prudential Life Ins. Co.	

\_\_\_\_\_  
**Proposed Insured's Signature (or that of Authorized Representative)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Proposed Insured**

\_\_\_\_\_  
**Agent Name (Printed)**

\*MIB is a nonprofit organization of life insurance companies and operates an information exchange for its members. Upon request of a member company, in connection with determining your eligibility for insurance, MIB may supply that member company with information in its file. Member life insurance companies and their reinsurers may make brief reports of certain medical and non-medical information to MIB regarding any person for who coverage is sought. If you contact MIB, it will disclose information it has about you in its file. If you feel the information in MIB's file is not correct, you can ask to correct the information as provided by the Federal Fair Credit Reporting Act. You can write MIB, Inc., PO Box 105 Essex Station Boston, MA 02112 or call (617) 426-3660.