Wealth Preservation & Management
311 Main Street, Irwin, PA 15642
Phone 800-517-9901 | Fax 804-482-2979

HIPAA Authorization to Release Information

PROPOSED INSURED INFORMATION

Proposed Insured/Patient Name _____Date of Birth_____SSN_____

This will authorize _____(*Physician, Clinic or Hospital Name*) to release medical information to Wealth Preservation and Management and its affiliated agencies.

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Wealth Preservation & Management and its affiliated agencies to disclose my personal financial and health information to the insurance companies listed below.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to my Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. 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, my prescription records and history of medication prescribed.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to Wealth Preservation & Management. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed below and their re-insurers as well as Wealth Preservation & Management and its staff, employees and affiliated companies. In addition, I also authorize the entire contents of the medical file compiled by the carrier, including but not limited to para-medical exam information, lab results, lab ticket documentation, medical records, applications, any and all medical correspondence and the like, to be released to Wealth Preservation & Management and its staff.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, Wealth Preservation & Management may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Proposed Insured/Patient Signature_____Date_____

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Agent's Signature | Agent's Name (Please Print) | City and State | Date

Accordia Life, Allianz Life Insurance Company of North America, American General Life Insurance Company, American National Insurance Companies, Americo Financial Life & Annuity Insurance Company, AXA Equitable Life Insurance Company, Banner Life Insurance Company, Cincinnati Life, Companion Life Insurance Company, EMC National Life, Fidelity Life, ForeThought, Genworth Financial Family of Companies, General Re Life Corp, Guardian Life Insurance Company, Hannover Re, John Hancock, Lincoln National Life Insurance Company, MassMutual, Metropolitan Life Insurance Company and MetLife Investors USA Insurance Company and their affiliates, Minnesota Life insurance Company, Munich Re, Mutual of Omaha, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, OneAmerica, Pacific Life Insurance Company, Principal Financial Group®, Principal Life Insurance, Principal National, Principal National Life, Protective, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York, RGA Re, Sagicor, Savings Bank Life Insurance Company of Massachusetts, SCOR, Security Life of Denver Insurance Company, The Standard, Sun Life Assurance Company of Canada, Swiss Re, Symetra Life Insurance Company, Transamerica Insurance & Investment Group, United of Omaha Life Insurance Company, United States Life Insurance Company in the City of New York, VOYA Life, William Penn Life Insurance Company of New York