



# AMERICAN BROKERAGE SERVICES, INC.

Toll Free: 1-888-227-3131  
Phone: 215-233-9410  
Fax: 215-233-9409

803 E. Willow Grove Ave  
Wyndmoor, PA 19038

## Authorization for the Release of Information – HIPAA Compliant

I, \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_ (“Patient” or “Insured”), hereby authorize any physician, doctor, nurse, physician practice group, medical practitioner, pharmacy, hospice, hospital, clinic or other medical or medically related facility or health care provider, insurance support organization, governmental agency, insurance company including but not limited to Zurich American Life Insurance Company, TransAmerica Financial, American General, and TransAmerica Family Markets, group policyholder, employer, benefit plan administrator, or any other institution or person (each, “Authorized Discloser”, hereafter referred to as, “AD”), to provide to American Brokerage Services, Inc. and/or its authorized representatives, affiliates, directors, officers, employees, agents, independent contractors, and service providers including Medical Review Services, LLC (collectively, “ABS”), any and all information as to diagnosis, treatment, and prognosis with respect to any physical or mental condition including psychiatric conditions, HIV and/or AIDS, or drug or alcohol abuse, or relating to the Insured, including any and all information that may indicate the presence of communicable or noncommunicable diseases.

This authorization allows the AD to disclose for inspection, copying and, as needed, use of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatment of the Insured. Information disclosed may also include any other information in the possession of the AD concerning any treatment or hospitalization of the Insured, including, but not limited to, all testing materials completed by or administered to the Insured, along with any and all medical charts, clinical or doctors’ notes, memoranda, medical reports, x-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control.

I specifically authorize insurance or support organizations holding Protected Health Information to release any life insurance policy or certificate information, including but not limited to, applications for insurance, forms, riders, illustrations, conversions, and amendments concerning the policy or certificate, and any other general information requested by ABS about my coverage.

I understand that the ABS will request only the minimum amount of information necessary to complete its review and will treat all information disclosed hereunder, including but not limited to Protected Health Information, as confidential. ABS will use the same level of care it uses with its own confidential information in using my personal information. ABS will only use or disclose the information for the purpose of obtaining life insurance quotes, a life insurance settlement or a related purpose. Furthermore, ABS will not release any confidential information to any person or organization except as permitted hereunder, as may be otherwise lawfully required or as I may further authorize. I understand that this transaction requires ABS to re-disclose the information to necessary third parties in order to complete the transaction, which may render it no longer protected under HIPAA privacy laws. I may revoke this Authorization at any time with respect to any AD by notifying such AD of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such AD. Any revocation shall not apply to the extent that the AD has taken action in reliance upon this Authorization prior to receiving notice of my revocation. Absent my revocation, this Authorization will expire twelve (12) months from its effective date.

I specifically authorize and request my insurance company and each AD to rely upon a photographic copy or facsimile copy or other reproduction of this Authorization. I am executing and delivering this Authorization freely and voluntarily as of the date written below. I have a full understanding of the Authorization’s contents and I will retain a completed copy for future reference. I agree that this Authorization shall remain valid until and will expire on the date of my death or until the case is declined, absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted by such law.



# ABS

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*The Career Company for Independent Agents*

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### Authorization for the Release of Protected Health Information HIPAA Compliant

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN #: \_\_\_\_-\_\_\_\_-\_\_\_\_

#### REQUESTOR/RECIPIENT INFORMATION

I hereby authorize (complete name and address of facility you wish to have records released from):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please disclose the following Protected Health Information to:

American Brokerage Services  
803 E. Willow Grove Ave  
Wyndmoor, PA 19038  
P: 888-227-3131 F: 267-420-1034

INFORMATION TO BE DISCLOSED:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PURPOSE OF DISCLOSURE: INSURANCE

I understand that I have the right to revoke this authorization at any time I understand that my revocation must be in writing and addressed to the privacy officer of the above facility authorized to make this disclosure. I understand that the revocation does not apply to information already released in reliance on this authorization.

Unless otherwise revoked, this authorization will expire one year from the date from which it was granted. originally signed or on the following date: \_\_\_\_\_



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### Authorization for the Release of Protected Health Information – HIPAA Compliant

#### Signature Page

\_\_\_\_\_  
Signature of Patient / Insured

\_\_\_\_\_  
Printed Name

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name

Date: \_\_\_\_\_