



# 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 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, of or relating to the Insured.

This authorization allows for the disclosure, inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatment of the Insured, and any other information in your possession concerning any treatment or hospitalization, 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 my insurance organizations or support organizations 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 treat all information disclosed hereunder as confidential and use the same level of care it uses with its own confidential information. ABS will only use 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-disclosure 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.

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.

[SIGNATURES APPEAR ON NEXT PAGE]



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### Signature Page

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

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

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

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

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

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

\_\_\_\_\_  
Signature of Policy Owner (*if not Insured*)

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

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