American Brokerage Services
The Career Company for Independent Agents **Toll Free:** 888.227.3131 **Fax**: 215.233.9409 **Web:** www.ABSgo.com

803-805 E. Willow Grove Ave.
Wyndmoor, PA 19038

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ (NAME OF INDIVIDUAL), AUTHORIZE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DEFINED UNDER THE PRIVACY REGULATIONS PROMULGATED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("PHI") AS FOLLOWS:

- Classes of Persons Authorized to Disclose My Protected Health Information: I authorize any doctor, hospital, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (each, an "HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I authorize each Authorized HCP to rely upon a photo static or facsimile copy or other reproduction of this authorization.

- Classes of Persons Authorized to Receive My Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to American Brokerage Services, Inc. and any of its affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, insurance support organization, insurance company, financing entities, stop-loss reinsurers, service providers or other representatives (each, an "Authorized Recipient").

- Protected Health Information Authorized for Disclosure: This authorization shall apply to any and all of my health and medical data, information and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This information may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other such related information.

- Purpose of Disclosure: This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (1) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured to the Authorized Recipient and (2) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured, including any conversions thereof or replacements therefore, that American Brokerage Services, Inc. brokers.

- Right to Revoke Authorization: I understand that 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 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 email or personal delivery at such address designated by such AD. Any evocation shall not apply to the extent that the AD has acted in reliance upon this Authorization prior to receiving notice of my revocation. Absent my revocation, this Authorization will expire twelve (l2) months from its effective date.

- Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization. No HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that this authorization is not a consent, or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that, because of this authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

- I certify that I am executing and delivering this authorization freely and unilaterally and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

Signature of Individual: _____ **Date:** _____

Printed Name of Individual: _____

Date of Birth: _____ **SSN:** _____

If the individual has an appointed personal representative, please sign below.

Signature of Representative: _____ **Date:** _____

Printed Name of Representative: _____

Description of Personal Representative's Authority:

(For example: Power of Attorney, Guardian ad Litem or similar status. *Please attach a copy any official document confirming this status*.)

Requestor/Recipient Information

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

Please disclose Protected Health Information to:

American Brokerage Services, Inc.
803-805 E Willow Grove Ave
Wyndmoor, PA 19038
Fax: 215.233.9409; 215.233.9390

If applicable, information to be disclosed for insurance purposes:
