AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION
RELEASE OF RECORDS
(In compliance with HIPAA Reg. § 45 CFR 164.508)

Proposed Insured/Patient's Name (Please type or print) Date of birth

_____ _____

First MI Last Month / Day / Year

I hereby authorize any health plan, hospital, physician, medical practitioner, clinic, other medically related facility, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, Medical Information Bureau (MIB), insurance agent, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers"), to release the protected health information in his/her/it/their possession concerning me, to my insurance agent's consultant **Strategic Medical Consulting, Inc. ("SMC"), 1427 W. 86th, Suite 363, Indianapolis, Indiana 46260**, or its representatives, employees, and agents, any and all information with respect to my medical, mental, and physical health (including but not limited to the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness and drug/alcohol abuse), and any injury and disability, including but not limited to the following information/documentation:

- Copies of all charts, records, correspondence, physicians' orders, progress notes, nurses' notes, medication records, therapy notes, laboratory reports, x-ray reports, consents, operative notes, pathology reports, anesthesia reports, admission and discharge summaries, prescriptions, and any other medical information.

- Copies of all itemized statements, bills, payment receipts and other financial records.

I further authorize My Providers to discuss with SMC, and/or its representatives, matters concerning my medical treatment, condition, prognosis and the records which are being requested. A photocopy of this authorization shall be deemed the same as one bearing my original signature.

I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations. (§ 45 CFR 164.508(c)(2)(3)).

I understand that I may revoke this authorization by notifying, in writing SMC, of my desire to revoke it. However, I understand that if I revoke this authorization it will not have any effect on actions taken by any covered entity that relies on it before I revoke it. (§ 45 CFR 164.508).

This information provided hereunder is to be used solely to assist my insurance agent in the evaluation, preparation, and/or process of procuring insurance for me. SMC is authorized to disclose and discuss matters concerning my medical treatment, condition, prognosis, prescriptions, medical information, and records with my insurance agent and insurance companies, and their representatives. I understand and hereby acknowledge, that there is no contractual, third-party beneficiary, and/or other relationship between SMC and me. This authorization shall remain in force for 24 months following the date of my signature below, unless I have provided previous written notice of revocation as described above.

_____ _____

Signature of proposed insured Name of proposed insured

_____ _____

Signature of additional proposed insured (if applicable) Name of additional proposed insured

_____ _____ _____

City State Month / day / year

Rev: 6/1/07