GREAT FIDELITY LIFE INSURANCE COMPANY
P.O. Box 9510, Wichita, Kansas 67277
•Telephone: 316-794-2200 •Fax: 316-794-8470 •Email: iai@iai-online.com

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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Name of proposed insured/patient/claimant

____
Application #, Claim #, Underwriting File #

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Name of second proposed/patient/claimant

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Health Care Provider") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to any of the insurance company named above, its employees, agents or representatives. 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, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so the insurance company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with this company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the insurance company at the administrative office address above. I understand that a revocation is not effective to the extent that any of My Health Care Providers has already relied on this authorization to disclose information about me or to the extent that the insurance company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the insurance company except as authorized by me or as required by law.

I understand that My Health Care Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the insurance company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

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Signature of proposed insured, patient or claimant or
Representative of such person

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Date

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Description of personal representative's authority or relationship