AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned individual, authorize the disclosure of my protected health information ("PHI") as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations") as follows:

SECTION 1. Classes of Persons Authorized to Disclose My Protected Health Information. I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I specifically authorize _____ to disclose any and all of my PHI as provided under this authorization. I acknowledge that all of my PHI in the possession of any Authorized HCP is necessary for the purpose for which this authorization is given as described below. I authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.

SECTION 2. Classes of Persons Authorized to Receive My Protected Health Information. I authorize each Authorized HCP to disclose my PHI under this authorization to _____, a_____, and any of its assigns, affiliates, directors, officers, employees, agents, independent contractors, service providers or other representatives (each, an "Authorized Recipient").

SECTION 3. Description of Protected Health Information Authorized for Disclosure and Purpose of 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, including information relating to psychiatric conditions (excluding psychotherapy notes), AIDS/HIV and/or drug or alcohol abuse/treatment, to the maximum extent permitted by applicable law. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient to analyze, assess, and evaluate my medical condition, in connection with the review, processing or adjustment of a claim made under a policy issued by the Authorized Recipient.

SECTION 4. Expiration of Authorization. This authorization shall remain valid and in force for the duration of the claim.

SECTION 5. Right to Revoke Authorization. I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation. However, I understand that if I revoke this Authorization to release my Health Information, Authorized Recipient may not be able to make an evaluation or process a claim.

SECTION 6. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization. I acknowledge and understand that no Authorized HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

SECTION 7. Authorization Not Requested by Health Care Provider, Clearinghouse or Plan. 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 HIPAA Privacy Regulations.

SECTION 8. Potential for Redisclosure. I further understand that, as a result 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 such Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

SECTION 9. Failure to Sign Authorization May Impact Ability of Authorized Recipient to Evaluate Claim. I understand that if I refuse to sign this Authorization to release my Health Information, Authorized Recipient may not be able to make an evaluation or process a claim.

SECTION 10. Certification. I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below 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 my future reference.

Signature: _____

Print Name: _____

Social Security Number:_____

Date:_____

If this authorization is being signed by a personal representative on behalf of the claimant, please provide the personal representative's name and describe relationship to the claimant and the authority to execute this authorization.

Name of Personal Representative: _____

Signature of Personal Representative: _____

Authority or Relationship to Claimant: _____

Date: _____

For your protection California law requires the following to appear on this form:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.