

ENTERPRISE LIFE INSURANCE COMPANY

**RELEASE OF INFORMATION AUTHORIZATION**

**Insured:** \_\_\_\_\_

**SSN:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I authorize any physician, hospital, insurance company, employer, contractor, financial or educational institution, and/or any specific entities indicated, to release any information regarding medical history, financial condition, education or employment history to Enterprise Life Insurance Company ("ELIC") or Union Security Life Insurance Company ("USLIC").

*SPECIFIC ENTITIES (if known):* \_\_\_\_\_

The medical information I authorize for release includes the following: medical history & physical, admission & registration, consultation & evaluation reports, doctor's orders & progress notes, laboratory/pathology reports, radiology/x-ray reports, operative/procedure reports, emergency room records and discharge summaries. The information I authorize for release may include information regarding mental health or illness, chemical or alcohol dependency, and sexually transmitted, communicable or venereal diseases which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS).

I understand that any of the above information requested by ELIC/USLIC will be used for the purpose of evaluating eligibility for insurance coverage and any claims for life or disability benefits made on behalf of the insured. I understand that once the above information is provided to ELIC/USLIC, it may be re-disclosed and may not be protected by federal privacy laws or regulations. I understand that it is ELIC/USLIC's policy not to release any information to third parties for any reason other than to evaluate eligibility for insurance or a claim for benefits.

I understand that authorizing the disclosure of information is voluntary and I can refuse to sign this authorization; however, I also understand that a refusal may result in ELIC/USLIC being unable to determine eligibility for coverage or benefits. I also understand that, as set forth in the HIPAA Privacy rules (45 CFR 164), my healthcare and the payment of my healthcare will not be affected if I refuse to sign this authorization. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present the written revocation to ELIC/USLIC. I understand that the revocation will not apply to an insurance company when the law provides the insurer with the right to contest a claim under the policy or to the extent that action has already been taken in reliance upon the authorization.

The information that I authorize for release shall include information up to 5 years prior to the date of my signature on this authorization, unless otherwise specified.

I also understand that this authorization will expire 5 years after the date of my signature, unless otherwise revoked. A photocopy of this authorization shall be as valid as the original.

**DATE:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_

**RELATIONSHIP TO INSURED:** \_\_\_\_\_