PO Box 349
Gadsden, AL 35902

Phone: 256-543-2022
Toll Free: 800-226-2371
Fax: 256-549-0070

Authorization to Release Information FORM

Policy Information (complete ALL of this this section)

Policy Number	Patient's Name	Date of Birth

I hereby authorize all medical sources including, but not limited to any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or service to me or on my behalf, the MIB and any prescription drug or pharmacy organization(s) Pharmacy Manager to provide Life Insurance Company of Alabama, or to Exam One/Quest Diagnostics, or to Frasco, on the behalf of Life Insurance Company of Alabama, information, data, or records concerning employment, motor vehicles, insurance, accidents, law enforcement and/or medical advice, care, treatment or health history provided to the person(s) named above, including, but not limited to, notes, reports, test results, x-rays, documents related to any mental conditions (excluding psychotherapy); cost of medical services, items or drugs; prognosis, physician notes of patient interviews, patient notes, pharmacy records or other data and including the full and complete clinical records, patient account information, hospital charts, examination records, disability and medical history.

I understand that this authorization is needed for the purpose of gathering information for evaluating and investigating claim(s) for insurance benefits, evaluating insurance applications and/or making eligibility, underwriting and risk rating determinations.

I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition; information relating to HIV testing, HIV status, or AIDS.

I understand that such information may be subject to special protections pursuant to law and that by signing this authorization, I authorize the person(s) or entity(s) listed to disclose records containing such information. I understand that medical providers may not condition treatment, payment, enrollment, or eligibility for benefits based on whether or not I sign this authorization. I acknowledge any agreements I made to restrict my protected health information do not apply to the authorization and I am instructing the medical providers to release and disclose my entire medical records.

Please list any special instructions. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at: Life Insurance Company of Alabama, Attn: Privacy Official, PO Box 349, Gadsden, AL 35902. I understand that the revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation or to the extent that Life Insurance Company of Alabama has the legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my insurance coverage ends (twenty-four (24) months from the date shown below in Kentucky and Oklahoma, thirty (30) months from the date shown below in Georgia and North Carolina), if not revoked before such date. I agree that a photo static copy of this authorization shall be considered as effective and valid as the original.

Signatures (complete ALL of this section)

Insured, Patient or legal representative's Name (print)	Insured, Patient or legal representative's Signature	Date
Mailing Address	Work, Home & Cell Phone	Email Address

Your relationship to the Patient (Check One):

☐ **Self**

☐ **Parent**: Include a copy of the Minor's birth certificate. (Guardianship appointment may be necessary)

☐ **Guardian:** Include a copy of the Guardianship, Court Order or Adoption papers

☐ **Representative of Patient's Estate:** Include a copy of the Personal Representative or Executor appointment.

☐ **Legal Caretaker:** Include a copy of the Power of Attorney or Conservator Appointment

☐ **Next of Kin**: State relationship _____ (Court or Personal Representative appointment may be necessary)

FRAUD NOTICE: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files or presents an insurance application and/or claim for payment of a loss or benefit or who knowingly presents false, incomplete, or misleading information in an application for insurance or claim is guilty of a crime, including a felony and may be subject to restitution fines or confinement in prison, or any combination thereof and may be prosecuted under state law.

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MEDICAL PROVIDER AND EMPLOYER LIST

Policy Number: _____
Claimant's Name:_____
Claimant's DOB: _____

Please list all Medical Providers for the Claimant. You may use additional paper as needed.

Medical Provider and Employer Information		
Employer Name	Address	Phone
Condition	Dates of Services	
Physician/Hospital Name	Address	Phone
Condition	Dates of Services	
Physician/Hospital Name	Address	Phone
Condition	Dates of Services	
Physician/Hospital Name	Address	Phone
Condition	Dates of Services	
Physician/Hospital Name	Address	Phone
Condition	Dates of Services	
Physician/Hospital Name	Address	Phone
Condition	Dates of Services	

FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.