AUTHORIZATION TO RELEASE HEALTH INFORMATION

Tennessee Farmers Life Insurance Company

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Applicant Name: _____ Address: _____

SS#: _____ DOB:_____ _____

A. **Who May Disclose:** The Applicant hereby authorizes the following persons or entities to release health information: (1) licensed health care professionals that have treated or are treating the Applicant; (2) allied health care professionals that have treated or are treating the Applicant; (3) health care facilities that have treated or are treating the Applicant; (4) mental health care facilities and professionals that have treated or are treating the Applicant; (5) pharmacy benefit manager; & (6) _____

B. **Information to be Disclosed:** The information requested pertains to medical information relevant to the Applicant's suitability for coverage of life insurance or any claim made against such life insurance policy. This includes any and all information concerning the Applicant's medical care, treatment or advice, including medical or other care records, diagnosis, pharmacy information & records deemed necessary by Tennessee Farmers Life to issue an insurance policy or determine the Applicant's eligibility for claims payment. This specifically authorizes the release of information relating to: ☑ Substance abuse (including drug or alcohol abuse); ☑ Mental health (excluding psychotherapy notes); and ☑ HIV related information (AIDS related testing or treatment). **The Applicant specifically authorizes the disclosure and release of his or her entire medical record upon request of Tennessee Farmers Life.** _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

C. **Please release the information to the following organization:**

Tennessee Farmers Life Insurance Company • P.O. Box 809, Waynesboro, TN 38485

D. **Purpose:** The purpose of the use or disclosure is: At the request of the Applicant for the purposes of underwriting, premium determination, or claims administration or adjudication.

E. **Right to Refuse:** The Applicant acknowledges that signing this authorization is voluntary and he/she has the right to refuse to sign this authorization; however, if he/she refuses to sign this authorization, the Applicant understands that Tennessee Farmers Life may not be able to gather the information necessary to determine if he/she, or an unemancipated minor child, is eligible for coverage under an insurance policy offered by Tennessee Farmers Life. Further, Applicant understands that he/she may refuse to sign this authorization and that a health care provider that is a covered entity may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on him/her signing this authorization.

F. **Revocation:** The Applicant acknowledges that he/she may revoke this authorization at any time by sending a written notice to the Privacy Officer at the address specified above in paragraph C. However, the revocation will not have any effect on any disclosures that a person or entity may have made in reliance on this Authorization before the revocation was received. Furthermore, the Applicant acknowledges that if he/she revokes this Authorization his/her application for life insurance may be declined or claims for benefits may be denied.

G. **Expiration:** The Applicant acknowledges that unless he/she revokes this Authorization, it will remain in effect from the date hereof and continue in effect until the application is denied or, if the application is approved, for thirty (30) months after the date signed.

H. **Redisclosure:** The Applicant acknowledges that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party, but will not be redisclosed by Tennessee Farmers Life except as authorized by the Applicant or as required by law.

I. **Certification:** I certify that I am *(check whichever applies)*:

- ☐ the Applicant, and the identification that I have provided is true and correct.
- ☐ the Applicant's authorized representative, with authority to consent to treatment and release of information on behalf of the Applicant, and the identification that I have provided is true and correct. My relationship to the Applicant is that of: _____.

J. I will receive a copy of this form after I sign it. I have read the above & authorize the disclosure of the protected health information as stated.

Signed this _____ day of _____, 20 _____. Address:

Signature: _____ _____

Print Name: _____ _____

SS#: _____ DOB:_____