LIBERTY NATIONAL LIFE INSURANCE COMPANY
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Authorization for Release of Health-Related Information

HIPAA Release

(For claims release only - not for new business applications)

This authorization is intended to comply with the HIPAA Privacy Rule

Full name of proposed insured/patient (please print) _____ Date of birth _____

Policy Number _____ Social Security Numer/Medical Record Number _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, MIB, Inc., or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the Liberty National Life Insurance Company (LNL) and its agents, employees, and 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 that LNL 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/or 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with LNL.

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 sending a written request for revocation to LNL to the attention of the Underwriting Department at the above address. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization, and that, to the extent that LNL has a legal right to contest a claim under an insurance policy or to contest the policy itself, such revocation may prevent LNL from completing their review of policy claims. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My 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, LNL may not be able to process my application, or if coverage has been issued, may not be able to process policy claims. I acknowledge that I have received a copy of this authorization. Liberty National Life Insurance Company and I agree that this Medical Provider History may be electronically signed. By typing my name below, I hereby agree that my electronic signature shall have the same effect as if it were handwritten. Further, I hereby attest that the information given herein is true and accurate to the best of my knowledge, and I understand that any false, misleading or fraudulent information may subject me to civil or criminal liability.

Signature of Proposed Insured/Patient or Personal Representative _____ Date _____

Personal Representative's Authority or Relationship to Patient, if Patient is under 18 years old. _____