

AUTHORIZATION FOR RELEASE OF INFORMATION

1. I (the undersigned) authorize any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; insurance or reinsurance company; government agency; department of labor; acquaintance; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

Claimant/Patient Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security Number: _____

2. Information to be released:
- data or records regarding my medical history, treatment, prescriptions, consultations, [including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition I may now have or have had];
 - any information regarding insurance coverage; and
 - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, Retirement Income, financial, earnings and employment history).
3. Information to be released to: Benefit Administrative Systems, Ltd.
17475 Jovanna Drive, Suite 1B
Homewood, IL 60430
4. I understand the information obtained by use of this Authorization will be used by the company to evaluate my claim. The Company will only release such information:
- to other persons or organizations performing business or legal services in connection with my claim(s); or
 - as otherwise may be required by law or as I may further authorize.
- I further understand that refusal to sign this Authorization may result in a delay in the determination of benefits.
5. I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
6. I understand that I may revoke this Authorization in writing at any time, except to the extent:
- 1) the Company has taken action in reliance on this Authorization; or
 - 2) the Company is using this Authorization in connection with a contestable claim.
- To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.
7. A photocopy of this Authorization is to be considered as valid as the original.
8. I understand I am entitled to receive a copy of this Authorization.

SIGNATURE: _____ **DATE:** _____

Claimant/legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/patient is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

PRINT NAME: _____

Relationship to Claimant/Patient or personal/legal representative signing for Claimant/Patient: _____

ADDRESS: _____ PHONE NO: (____) _____
(Street)

(City) (State) (Zip Code)