QUALITY QUOTE
INSURANCE SOLUTIONS
INNOVATIVE ADVISOR SERVICES

FINANCIAL AND MEDICAL RECORDS AUTHORIZATION
(This authorization complies with the HIPAA Privacy Rule)
Give completed and signed copy to Proposed Insured

Name of Proposed Insured/Patient (please print) _____

Date of Birth _____ S.S.#_____

Name of Additional Proposed Insured/Patient (please print) _____

Date of Birth _____ S.S.# _____

I authorize Blackstone Alliance, the agent/broker named below, Insurance support organizations (such as MIB, Inc), the companies listed at the bottom and their reinsurers, agents, employees and representatives to obtain medical and other information. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider, insurance company, the Medical Information Bureau, Inc., employer, consumer reporting agency, or other organization, institution or person that has information available as to my employment or other Insurance coverage, or has provided payment, medical care, treatment, supplies, advice or services to me or on my behalf within the past 10 years ("My Providers") to disclose such information, including my entire medical record and any other protected health information concerning me to the individuals/entities named above. 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 My Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization at my request, as permitted by §164.508(c)(1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

My protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage by making eligibility, risk rating, policy/certificate 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 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company(s).

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 Blackstone Alliance, 139 Charles Street, Boston, MA 02114, Attention: HIPAA Privacy Official. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective to the extent that any of My Providers have relied on this authorization or to the extent that the companies listed below have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as HIPAA Privacy Rule).

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, my application may not be processed, or if coverage has been issued benefit payments may not be made. I acknowledge that I have read and received a copy of this authorization.

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

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

If this authorization has been signed by a personal representative of the proposed insured/patient, please describe the basis for the personal representative's authority to act on behalf of the proposed insured/patient:

_____

Name of Agent/Broker _____

Signature _____ Date _____

Companies to Which This Authorization Applies:

Accordia Life & Annuity
AIM Systems, Inc.
Allianz Life
American Equity
Allstate Life Ins. Co. of NY
American General
American National
Ameritas Life
Asher Group
Assurity Life
Athene
AXA
Banner Life
Bluestone Insurance Group
Cincinnati Life
Companion Life
Coventry
Dynamic Imaging
EMSI
Exam One
Foresters
Gerber Life
Guardian Life
Hooper Holmes/Portamedic
John Hancock USA
Legal & General America
Liberty Life
Life of the Southwest
Lincoln Financial Group
Lloyd's of London
Mass Mutual
MetLife
Minnesota Life
Mutual of Omaha
National Life
Nationwide
New York Life
North American
One America
Pacific Life
Park & Elm Brokerage
Penn Mutual
Principal Financial Group
Presidential Life
Protective Life & Annuity
Prudential Financial
Quality Quote Ins. Solutions
SBLI
Securian Life
Symetra
Transamerica Life
Trumark Financial
United of Omaha
Voya
Wm Penn