

# INVESTORS HERITAGE *Life Insurance Company*

## JOINT HIPAA Compliant Authorization for Release of Medical Information for Underwriting UNDERWRITING ONLY

_____ Name of primary proposed insured/ patient	_____ Social Security Number	_____ / / Date of Birth
_____ Name of joint proposed insured/ patient	_____ Social Security Number	_____ / / Date of Birth
_____ Policy Number (if known)		

I authorize any health plan, physician, health care professional, hospital, Veterans Administration, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, insurance company, insurance support organization such as MIB), or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (collectively, "My Providers") to disclose my entire medical record, medication history, and any other protected health information concerning me to **Investors Heritage Life Insurance Company, or its designee,**

\_\_\_\_\_  
Name of designee (if applicable)

This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STDs). 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 my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that **Investors Heritage Life Insurance Company** may: (1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; (2) obtain reinsurance; (3) 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 **Investors Heritage Life Insurance Company**.

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 **Investors Heritage Life Insurance Company**, P.O. Box 717, Frankfort, KY 40602, Attn: General Counsel. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization or to the extent that **Investors Heritage Life Insurance Company** has 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 redisclosure by the recipient and may no longer be protected by federal rules governing privacy and confidentiality of health information. However, **Investors Heritage Life Insurance Company** will protect the privacy of health information in accordance with other applicable state and federal privacy laws and their own privacy policies.

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, **Investors Heritage Life Insurance Company** may not be able to process my application. I understand that my authorized representative or I am entitled to a copy of this signed authorization.

\_\_\_\_\_  
Signature of Primary Proposed Insured/Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Joint Proposed Insured/Patient or Personal Representative

\_\_\_\_\_  
Date