Authorization for Release of Information

1. I (the undersigned) authoriz			
	(Provider/Fac	ility Name)	
(Street)	(City/State)	(Zip Code)	(Phone Number) Business Mobile
To release information from the	ne record(s) of:(Patient La	ast Name) (First Name)	(Middle)
Date of Birth://	Soc. Sec. No. (last 4	digits):	
Covering the period(s) of treat	tment:		
2. Information to be released	(please initial by all that app	ly):	
 All Records Cath Films Discharge Summary Evaluations & Summaries MRI Scans Pathology Slides Ultrasounds Complete Medical Record (in from other facilities). Other: 	Abstracted Chart CT Scans Echocardiogram Tapes Fetal Monitor Strips Nurse's Notes Progress Notes Videos Videos	Admission Claims History Education Reports History & Physical Operating Room Report Radiation Records X-ray Films insurance demographics, referral o	Billing Consultation EKGs Lab Reports Pathology Report Social History X-ray Reports documents and records
3. Information is to be release	ed to:		
Examination Manageme 109 West Panther Way Waco TX 76712	Addr City,	For Combined Ins	orporation, Administrator urance Company
information has already occurr is not received, authorization signing. To initiate revocation of	ay be revoked in writing at an ed prior to the receipt of revo will be considered valid for a of this authorization direct all o	by time. With the exception to the ocation by the above named prove a period of time not to exceed s correspondence to the "Specific	vider. If written revocation 00 days from the date of
6. I understand that this conse			
Alcohol and/or drug abu Sexually transmitted dise		Psychiatric records HIV/Aids information	
7. A photocopy of this author			
		bility for benefits may not be co	nditioned on signing this
application for insurance to ad Physician; Medical Practitione organization; Health Plan; oth Bureau, Inc., (MIB); Consumer	cquire, review, research the re r; Clinic; Pharmacy; Pharmac ner medical or medically rela Reporting Agency; Combine	ca or its reinsurers for the pur elease of information from any c by Benefits Manager or other phated facilities; Government Ager ed's own records. with it the potential for re-disclo	of the following: Hospital; narmacy-related services ncy; Medical Information
may then no longer be protec		•	
SIGNATURE:		Date:	
Patient or personal/legal replincompetent, or deceased). PRINT NAME:		egal guardian to sign only if pa	atient is a minor, legally
		gning for patient:	

Instructions for Authorization for Release of Information

1. I (the undersigned) authorize			
	(Provider/Facility	y Name)	
(Street)	(City/State)	(Zip Code)	(Phone Number)
To release information from the reco	ord(s) of:		
	(Patient Last	Name) (First Name)	(Middle)
Date of Birth://	_ Soc. Sec. No. (last 4 di	gits):	
Covering the period(s) of treatment			
2. Information to be released (pleas	e initial by all that apply)):	
Cath Films C Discharge Summary E Evaluations & Summaries F MRI Scans N	Echocardiogram Tapes Fetal Monitor Strips Nurse's Notes Progress Notes /ideos es information regarding i	 Admission Claims History Education Reports History & Physical Operating Room Report Radiation Records X-ray Films nsurance demographics, referral 	Social History X-ray Reports
3. Information is to be released to:	FOR (Specific Rec	uestor Info)	
Examination Management Services 109 West Panther Way Waco, TX 76712	Company:	Vision Financial Corporation, Administrator for Combined Insurance Company of America	
	Address:	PO Box 506	
	City, State, Zip: Keene, NH 03431		
4. Purpose of disclosure:Life /	Health Insurance		
5. I understand this consent may be r information has already occurred pric is not received, authorization will be	revoked in writing at any t or to the receipt of revoca	tion by the above named provid	der. If written revocation

signing. To initiate revocation of this authorization direct all correspondence to the "Specific Requestor" above. 6. I understand that this consent is to include disclosure of: (PLEASE INITIAL):

	Alcohol and/or drug abuse record	Psychiatric records
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Sexually transmitted disease information HIV/Aids information

7. A photocopy of this authorization is to be considered as valid as the original.

8. Treatment, payment, enrollment in a health plan, or eligibility for benefits may not be conditioned on signing this authorization.

9. I authorize Combined Insurance Company of America or its reinsurers for the purpose of evaluating this application for insurance to acquire, review, research the release of information from any of the following: Hospital; Physician: Medical Practitioner; Clinic; Pharmacy; Pharmacy Benefits Manager or other pharmacy-related services organization; Health Plan; other medical or medically related facilities; Government Agency; Medical Information Bureau, Inc., (MIB); Consumer Reporting Agency; Combined's own records.

10. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may then no longer be protected by Federal confidentiality rules.

SIGNATURE:

_____ Date:_____

Patient or personal/legal representative (Next-of-kin or legal guardian to sign only if patient is a minor, legally incompetent, or deceased). PRINT NAME: _____

Relationship to patient or personal/legal representative signing for patient: