PENN TREATY

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POLICYHOLDER AUTHORIZATION TO RELEASE INFORMATION

Policyholder name _____ Policy number _____

PLEASE PRINT

AUTHORIZATION: I authorize American Network Insurance Company, hereinafter referred to as "American Network," to release written and/or verbal information about my insurance policy and claim, including my medical care and treatment and other non-medical information as deemed necessary by American Network, to the following individuals:

Name (please print)	Relationship	Telephone number

REVOCATION: I understand that I have the right to revoke this authorization. Such revocation must be sent in writing to American Network at 3440 Lehigh Street, Allentown, PA 18103 and will become effective when received by American Network. I understand that even if I revoke this authorization, American Network will, and will be permitted to disclose information as required or permitted by law and as permitted by other authorizations I have given American Network, and in accordance with its notices of information practices.

DISCLOSURE AND REDISCLOSURE: American Network cannot guarantee that the individuals I have authorized will not disclose or re-disclose my personal information. If disclosed under this authorization, protected health information is no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) and state and federal laws.

PERIOD OF VALIDITY: This authorization shall be valid from the date signed for either six (6) months, or as long as my policy remains in force, whichever is later, unless revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original.

Signed _____ Date _____

Name (please print) _____

If this authorization is signed by a personal or legal representative of the applicant/insured, complete the following:

Personal/legal representative's name _____

Relationship to applicant/insured _____

Basis for representation (POA, guardian, etc.) _____

PLEASE ATTACH COPY OF LEGAL DOCUMENT