AMERICAN NETWORK

tel 800.362.0700
fax 610.965.6962
www.penntreaty.com

HIPAA COMPLIANT AUTHORIZATION TO RELEASE INFORMATION

Authorization: I authorize and direct any physician, medical practitioner, hospital, clinic, care provider, other medical or medically related facility; residential, residential care, or residential treatment facility, social service organization, insurance support organization, insurance company, reinsurance company, benefit plan administrator, pharmacy, attorney, consumer reporting agency, employer, state or federal government agency including the Social Security Administration, or other entity having information about me to release to American Network Insurance Company, hereinafter referred to as "American Network," or its agents or representatives, any and all information they possess concerning my medical care, treatment or advice including medical or other care records, diagnosis, pharmacy information including information about drug or alcohol abuse, HIV, AIDS, mental and/or nervous conditions (except psychotherapy notes), and other non-medical information as deemed necessary by American Network to underwrite an insurance policy or determine my eligibility for benefits, including information I directed be withheld.

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 if I refuse to sign this authorization, or if I revoke this authorization, American Network may not be able to issue a policy to me and/or may be unable to determine my eligibility for benefits under a policy that is issued. I understand that even if I revoke this authorization, American Network will, and will be permitted to, obtain and disclose information as required or permitted by law and in accordance with its notices of information practices.

Disclosure and Redisclosure: American Network will only disclose or re-disclose information as required or permitted by law and in accordance with its notice of information practices.

Period of Validity: This authorization shall be valid; for underwriting - from the date signed for twelve (12) months; for claims - from the date signed for either twelve (12) 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.

Copy Received: I, the undersigned, acknowledge that I have received a copy of this authorization.

Signature _____ Date _____

Applicant or policyholder name _____ Policy number _____
(PLEASE PRINT)

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

Personal/legal representative's name _____

Relationship to applicant/insured _____

Basis for representation (POA, Guardian, etc.) _____
(PLEASE ATTACH COPY OF LEGAL DOCUMENT)