**Authorization to Use or Disclose Individually Identifiable Health Information**
**This is a Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliant Form**

**Patient Name** _____ **Policy Number** _____

**"Information Provider"** as used herein may include any physician, medical practitioner, hospital, clinic, other medical or medically related facility, clearinghouse, insurance or reinsuring company (including affiliated companies of the Company), agent, broker, service provider, Medical Information Bureau, Inc. (MIB), credit bureau or other consumer reporting agency, employer or the Veterans Administration.

**"Information"** received from an Information Provider may include diagnosis, prognosis, treatment or care of any physical or mental condition concerning the patient and/or the claimant, including information about HIV, drug or alcohol abuse or mental illness (expect psychotherapy notes) and/or financial, consumer report, or any other non-medical information or personal information concering me.

**1. Authorization. I hereby authorize** any information Provider to give Gerber Life Insurance Company and/or A. C. Newman & Company (the Company) any and all information regardless of any previous restriction or limitation on disclosure of such information. In order to expedite my request, I further authorize an Information Provider (except MIB) to release information to the Company's agents, brokers, service providers, its re-insurers, or any other third party retained by the Company to collect and transmit such information.

**2. Use of the Information and Expiration Date. I understand** that the Information obtained by use of this Authorization is at my request and will be collected by the Company for the administration of the claim(s) against the policy captioned above. I understand that this Authorization to Use or Disclose Individually Identifiable Health Information shall remain valid for twenty-four (24) months from the date shown below. I understand that if I do not sign this Authorization, the Company may not be able to process my claim for insurance benefits. I also understand that my refusal to sign this Authorization does not affect my ability to receive treatment from my physician or other health care provider.

I understand that the Company may maintain or have access to personal information acquired separately through any of my previous insurance applications with the Company or its Affiliates for insurance where insurance was not placed with the patient and/or the claimant. I authorize the Company to use or disclose such information in the administration of my current claim(s).

**3. Revocation. I understand** that I may revoke this Authorization at any time by providing written notice to the Company at the address below, except: (i) to the extent that an individual has taken action in reliance upon such Authorization prior to notice of the revocation, or (ii) to the extent that this authorization was provided as a condition to obtaining insurance coverage and other law provides the Company with the right to contest a claim for coverage under the policy or the policy itself.

**A.C. Newman & Company**
**7060 N. Marks Avenue, Suite 108**
**Fresno, CA 93711**

**4. Re-disclosure. I understand** that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer the responsibility of the Information Provider or protected by the privacy rule under the Health Insurance Portability and Accountability Act (HIPPA).

**5. Copy Valid as Original. I agree** that a copy of this Authorization is as valid as the original.

_____ _____
Patient's, Claimant's or Authorized Representative's Signature | Description of Representative's Authority (if Applicable)

_____ _____
Patient's Printed Name | Patient's Social Security Number

_____ _____ _____
Patient's Date of Birth | Policy Number | Date