APPEL INSURANCE ADVISORS LLC

STEPHANIE A. TIMMONS

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HIPPA Compliant Authorization for Release of Health-Related Information
Appel Insurance Advisors, LLC
(Hereinafter referred to as The Company)

Name of proposed Insured/Patient: Date of Birth:

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (hereinafter referred to as My Providers) to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to The Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. This also includes a release of data from the Medical Information Bureau (MIB).

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 any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Company may: 1) provide the data obtained to all insurance companies that are participating in the underwriting of insurance coverage on my life; and 2) to allow those insurers to: a) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; b) obtain reinsurance; c) administer claims and determine or fulfill responsibility for coverage and provision of benefits; d) administer coverage; and e) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company or the insurers.

This Authorization shall remain in force for 9 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 providing written notification to The Company at the address below. I understand that a revocation is not effective to the extent that any of My Providers

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have already relied on this Authorization to disclose information about me or to the extent that the insurers have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by The Company or the insurers except as authorized by me or as required by law. I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, neither The Company nor the insurers may be able to process my application, or if coverage has been issued may be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this Authorization upon request.

Signed at_____This_____Day of_____Year_____

Signature of Proposed Insured/Patient:

_____

Send all data via fax or mail to:
Appel Insurance Advisors
One Gateway Center, Suite 305
Newton, MA 02458
PH: 617-332-7900 F: 617-527-0681