

## MEDICAL RECORDS AUTHORIZATION FORM

Please complete and return this authorization form. It will enable us to order necessary medical records to best evaluate your claim. If the claim is for a person other than the primary policyholder, such as a spouse, have them sign in the appropriate space. If it is a covered child listed in the policy, please be sure to identify that person by date of birth. Print a duplicate form to retain for your records.

Primary Covered Person \_\_\_\_\_ Policy Number \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Date of birth \_\_\_\_\_

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996, 45 CFR 164.508. It authorizes Southwest Service Life Insurance Company, to use my complete medical records, and those of my family members whose names appear in my application for health insurance, for the purpose of insurance underwriting, risk review, claims adjudication and other health plan insurance operations.

The person/people/entities authorized to make this disclosure to Southwest Service Life Insurance Company is/are my physicians, medical practitioners, hospitals, clinics, medical facilities or other health care providers having records or knowledge of my health and those of my family members whose names appear in my application for health insurance.

The confidentiality of my healthcare information is waived by this authorization, which permits disclosure of any and all requested parts of my medical records. I understand this may include drug, alcohol, mental health, HIV or AIDS information. I understand that redisclosure may not be protected.

This authorization is valid for two years following the date written below and will expire. Under the Privacy Rules, I have the right to revoke this authorization at any time, and Southwest Service Life Insurance Company must cease using this authorization. However, Southwest Service Life Insurance Company may complete any actions it initiated prior to my revocation and which rely on my complete medical records for completion. I must revoke this authorization in writing and send the revocation to Southwest Service Life Insurance Company, P.O. Box 982005, Fort Worth, Texas 76182-8005

Policyholder Signature \_\_\_\_\_ Date \_\_\_\_\_

Please complete, if applicable:

Other Adult Signature \_\_\_\_\_

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Print name(s) of covered children:      Date of Birth


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