Atlantic Financial
Life • Annuity • Long Term Care

HIPAA AUTHORIZATION TO OBTAIN AND RELEASE HEALTH-RELATED INFORMATION

Records and information obtained will be disclosed to: Atlantic Financial

The purpose of this disclosure is to evaluate my application for insurance, claim benefits, life settlement transactions or other insurance related transactions. I hereby authorize for you to release any and all records regarding genetic testing. H.I.V./AIDS status, drug abuse and alcohol abuse, behavioral health, and mental health. I understand this will not give the ability or inability to condition my treatment, payment, enrollment, or eligibility for benefits.
I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, or anyone else located at:

Facility Name:

Address:

To release any and all records and information regarding:

Patient's Name:

First Middle Last

Other Name Used:

Date of Birth: Social Security Number:

Specifics to be released:

To be released to and exchanged between the insurance company first named above, and:

Atlantic Financial
171 Market Square, Suite 106, Newington, CT 06111

and their agents, contractors, employees, life expectancy providers, life settlement providers, proposed financing entities, authorized representatives, affiliates, and assignees as necessary to fulfill the purpose of this disclosure.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of six (6) months from my date of signature below or until the request is filled).
I understand I may revoke/cancel this authorization at any time by requesting such of EMSI or (name of facility visiting) _____ in writing at its address stated above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

Date:

Signature of patient/guardian/personal representative/
power of attorney (specify and include copy):

Legal relationship to application:
(Only if signed above by guardian or personal representative)

Witness Signature:
(Only if required)

Witness Required
(Only if marked)

Notary Signature:
(Only if required)

Notary Required
(Only if marked)