

## Authorization To Release Information

I authorize any medical practitioner or facility or related entity to give any information about me or my mental or physical health to \_\_\_\_\_, Atlantic Brokerage Partners LLC, Max Broker Services LLC, Agent Resources Inc. and/or its authorized agents to determine my eligibility for insurance and/or benefit payment. The information authorized for release includes my entire medical record, excluding psychotherapy notes, but including any information regarding medications used, drug and alcohol treatment, and communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). It also includes motor vehicle records.

**For purposes of this Authorization, I hereby revoke any prior restriction on disclosure of my medical records, and authorize the release of my entire medical records to the company, excluding psychotherapy notes.**

This authorization may be revoked at anytime by writing to us at Atlantic Brokerage Partners LLC. P.O. Box 1476 Sayville, NY 11782-0218. Revocation or alteration of this authorization may mean that we will not be able to complete the application process.

The company may retain and disclose information to the Medical Information Bureau, reinsurers, or for insurance underwriting, policyholder service or claim handling, to others who perform services for us, or as otherwise allowed by law. Any revocation of this authorization will not impact these rights of disclosure.

Once disclosed to the company, the information will no longer be protected by the Health Insurance Portability and Accountability Act, but will be protected by other federal and state laws relating to the protection of personal information.

This authorization also applies to any member of my family proposed for coverage in the application and is valid for two years after the date below

A copy of this authorization will be provided to me by the insurance representative or the company, either at the time of execution or shortly thereafter. I understand my representative can tell me how and when I will receive a copy. A photocopy of this Authorization is as valid as the original.

I have read and agreed to all the terms of this form.

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

**X** \_\_\_\_\_ **Date:** \_\_\_\_\_

Signature of proposed insured  
(If age 15 or over, otherwise applicant)

Company Copy

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(If age 15 or over, otherwise applicant)

Proposed Insured Copy