Penn Treaty Network America Insurance Company℠

(PTNA Life Insurance in CA)

American Network Insurance Company℠

HIPAA COMPLIANT AUTHORIZATION TO RELEASE INFORMATION

AUTHORIZATION: I authorize and direct any physician, medical practitioner, hospital, clinic, care provider, other medical or medically related facility; residential, residential care, or residential treatment facility, social service organization, insurance support organization, insurance company, reinsurance company, benefit plan administrator, pharmacy, attorney, consumer reporting agency, employer, or other entity having information about me to release to Penn Treaty Network America Insurance Company, American Network Insurance Company and/or and American Independent Network Insurance Company, hereinafter collectively referred to as "Penn Treaty", or its agents or representatives, any and all information they possess concerning my medical care, treatment or advice including medical or other care records, diagnosis, pharmacy information including information about drug or alcohol abuse, HIV, AIDS, mental and/or nervous conditions (except psychotherapy notes), and other non-medical information as deemed necessary by Penn Treaty, *including information I directed be withheld.*

REVOCATION: I understand that I have the right to revoke this authorization. Such revocation must be sent in writing to Penn Treaty at 3440 Lehigh Street, Allentown, PA 18103 and will become effective when received by Penn Treaty. I understand that if I refuse to sign this authorization, or if I revoke this authorization, Penn Treaty may not be able to issue a policy to me and/or may be unable to determine my eligibility for benefits under a policy that is issued. I understand that even if I revoke this authorization, Penn Treaty will, and will be permitted to, obtain and disclose information as required or permitted by law and in accordance with its notices of information practices.

DISCLOSURE AND REDISCLOSURE: Penn Treaty will only disclose or re-disclose information in accordance with its notice of information practices.

PERIOD OF VALIDITY: This authorization shall be valid from the date signed for either six (6) months, or as long as my policy remains in force, whichever is later, unless revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original.

COPY RECEIVED: I acknowledge that I have received a copy of this authorization.

Signed _____ Dated _____

Name (please print) _____

If this authorization is signed by a personal or legal representative of the applicant/insured, complete the following:

Personal/Legal Representative's Name _____

Relationship to Applicant/insured _____

Basis for Representation (POA, Guardian, etc.) _____

(PLEASE ATTACH COPY OF LEGAL DOCUMENT)

Home Office Copy (White) Applicant's Copy (Canary)