American Income Life Insurance Company
P.O. Box 2608
Waco, TX, 76797

Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule

(Print full name of patient and birth date)

_____ _____ _____
Name DOB Social Security Number/ Medical Record Number

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, Medical Information Bureau (MIB), or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the American Income Life Insurance Company (AIL) and its agents, employees, and representatives. 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.

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 AIL may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with AIL.

This authorization shall remain in force for 24 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 sending a written request for revocation to AIL, Attention: Claims Department, at the above address. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that AIL has 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 may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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, AIL may not be able to process my claim or make any benefit payments. I have received a copy of this authorization.

_____ _____
Signature of Patient/Beneficiary/Guardian or Personal Representative Date

_____
Personal Representative's Authority or Relationship to Patient, if patient under 18 years old

Two copies are provided. Sign one copy and return. Keep one copy for your records.