

Access Authorization

Persons authorized to request information about your AAFMAA records

Please PRINT clearly in blue or black ink. Original signature required (no faxes).

1. PERSON GRANTING ACCESS	AAFMAA Number (if known)
Name (Last, First MI)	Social Security Number

2. PERSON(S) RECEIVING ACCESS		
List person(s) to whom AAFMAA may provide information		
Name (Last, First MI)	Social Security Number	Relationship

3. AUTHORIZATION FOR PERSONAL INFORMATION	
I hereby authorize the Army and Air Force Mutual Aid Association to provide <u>my personal</u> information and send copies or original documents to the person(s) listed above upon their request. I understand that this authorization includes medical and financial records, but does not include the authority to request changes.	
Signature	Date Signed (mm/dd/yyyy)

4. AUTHORIZATION FOR OWNED POLICY INFORMATION	
I hereby authorize the Army and Air Force Mutual Aid Association to provide information and copies of records regarding the certificates of insurance <u>I own</u> to the person(s) listed above upon their request. I understand that this authorization does not include my personal, medical or financial information or the authority to request changes.	
Signature	Date Signed (mm/dd/yyyy)

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