

Applicant Medical Release

HIPAA compliant authorization for release of medical information to AAFMAA

Please PRINT clearly in blue or black ink.

1. INSURED	AAFMAA number (if known)
Name (First MI Last)	Social Security Number

2. REPRESENTATIVE (if other than insured)	
Name (First MI Last)	Relationship to Insured
	Description of authority

3. AUTHORIZATION
<p>I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider ("Provider") that has provided payment, treatment or services to or on behalf of myself (or the person whom I represent) as listed above ("Insured") to disclose the entire medical record, prescription history, medications prescribed and any other protected health information concerning the Insured to AAFMAA, its employees, agents or 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.</p> <p>By my signature below, I acknowledge that any agreements that have been made to restrict protected health information do not apply to this authorization and I instruct any Provider to release and disclose the entire medical record without restriction.</p> <p>This protected health information is to be disclosed under this Authorization so that AAFMAA may:</p> <ol style="list-style-type: none">1) underwrite an application for life insurance coverage, make eligibility, risk rating, policy issuance and enrollment determinations;2) obtain reinsurance;3) administer claims and determine or fulfill responsibility for coverage and provision of benefits;4) administer coverage; and5) conduct other legally permissible activities that relate to any current or pending coverage with AAFMAA. <p>This authorization shall remain in force for 26 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 providing written notification of AAFMAA. I understand that a revocation is not effective to the extent that any Provider has already relied on this Authorization to disclose information about the Insured or to the extent that AAFMAA 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 is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by AAFMAA except as authorized by me or as required by law.</p> <p>I understand that 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, AAFMAA may not be able to process an application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.</p>

4. SIGNATURE OF INSURED OR REPRESENTATIVE	
Signature	Date (mm/dd/yyyy) / /