



# Grange Life Insurance Company

671 South High Street - PO Box 1218  
Columbus, Ohio 43216-1218

## HIPAA Compliant Authorization for Release of Medical Information

\_\_\_\_\_  
Name of Proposed Insured/Patient (please type or print)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of birth

I **authorize** any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, including any facility run by the Veteran's Administration, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, or the medical records of my minor children, prescription history, medications prescribed and any other protected health information concerning me or my minor children to Grange Life Insurance Company. 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. This information can also be released by insurers, reinsurers, the Medical Information Bureau (MIB), employers and consumer reporting agencies.

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 Grange Life Insurance Company may: 1) underwrite my application for 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; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Grange Life Insurance Company.

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 providing written notification to the entity identified above, I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that Grange Life Insurance Company 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 Grange Life Insurance Company except as authorized by me or as required by law.

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, Grange Life Insurance Company may not be able to process my 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.

I authorize Grange Life Insurance to obtain an investigative consumer report on me. In connection with any investigative consumer report,

I/We  do  do not request a personal interview.

I have received a copy of the Notice of Information Practices.

**\* Virginia Only:** The authorization to disclose protected health information in connection with a claim for benefits under this policy will remain valid during the claims review process.

Date: \_\_\_\_\_ (x) \_\_\_\_\_  
Signature of Proposed Insured #1  
Personal Representative

(x) \_\_\_\_\_  
Signature of Proposed Insured #2  
Personal Representative

(x) \_\_\_\_\_  
Signature of Parent or Guardian,  
if minor child(ren) proposed for insurance

(x) \_\_\_\_\_  
Description of Personal Representative's Authority  
or Relationship to Patient