Authorization for Release of Information

1. I (the undersigned) authorize _____
(Provider/Facility Name)

_____
(Street) (City/State) (Zip Code) (Phone Number) Business Mobile

To release information from the record(s) of: _____
(Patient Last Name) (First Name) (Middle)

Date of Birth: ____/____/_____ Soc. Sec. No. (last 4 digits): _____

Covering the period(s) of treatment: _____

2. Information to be released (please initial by all that apply):

__ All Records __ Abstracted Chart __ Admission __ Billing
__ Cath Films __ CT Scans __ Claims History __ Consultation
__ Discharge Summary __ Echocardiogram Tapes __ Education Reports __ EKGs
__ Evaluations & Summaries __ Fetal Monitor Strips __ History & Physical __ Lab Reports
__ MRI Scans __ Nurse's Notes __ Operating Room Report __ Pathology Report
__ Pathology Slides __ Progress Notes __ Radiation Records __ Social History
__ Ultrasounds __ Videos __ X-ray Films __ X-ray Reports
__ Complete Medical Record (includes information regarding insurance demographics, referral documents and records from other facilities).
__ Other: _____

3. Information is to be released to:

Examination Management Services
109 West Panther Way
Waco TX 76712

FOR: Company: Vision Financial Corporation, Administrator For Combined Insurance Company
Address: P O Box 506
City, State, Zip: Keene NH 03431

4. Purpose of disclosure: **Life/Health Insurance**

5. I understand this consent may be revoked in writing at any time. With the exception to the extent that disclosure of information has already occurred prior to the receipt of revocation by the above named provider. If written revocation is not received, authorization will be considered valid for a period of time not to exceed 90 days from the date of signing. To initiate revocation of this authorization direct all correspondence to the "Specific Requestor" above.

6. I understand that this consent is to include disclosure of: (PLEASE INITIAL):

____ Alcohol and/or drug abuse record ____ Psychiatric records
____ Sexually transmitted disease information ____ HIV/Aids information

7. A photocopy of this authorization is to be considered as valid as the original.

8. Treatment, payment, enrollment in a health plan, or eligibility for benefits may not be conditioned on signing this authorization.

9. I authorize Combined Insurance Company of America or its reinsurers for the purpose of evaluating this application for insurance to acquire, review, research the release of information from any of the following: Hospital; Physician; Medical Practitioner; Clinic; Pharmacy; Pharmacy Benefits Manager or other pharmacy-related services organization; Health Plan; other medical or medically related facilities; Government Agency; Medical Information Bureau, Inc., (MIB); Consumer Reporting Agency; Combined's own records.

10. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may then no longer be protected by Federal confidentiality rules.

SIGNATURE: _____ Date: _____

Patient or personal/legal representative (Next-of-kin or legal guardian to sign only if patient is a minor, legally incompetent, or deceased).
PRINT NAME: _____

Relationship to patient or personal/legal representative signing for patient: _____