



Pickett Group, Inc.
14805 N. Outer Forty, Ste. 230
Chesterfield, MO 63017
(636)519-0977

HIPAA Authorization for Release of Health-Related Information

Name of Patient/Proposed Insured: _____

DOB: _____ **SSN:** _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB, Inc.), or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose the entire medical record and any other protected health information concerning me to the Company(ies) reference below, their agents, employees, and representatives. 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 My Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization at my request, as permitted by Sec. 164.508(c)(1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This authorization shall remain in force for 12 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 the Company(ies) at the address(es) listed above, Attention: HIPAA Privacy Official. Alternatively, I may revoke this authorization by sending a written revocation request directly to My Providers.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this form. I also understand that if I refuse to sign this authorization to release my complete medical record that the Company(ies) may not be able to process my application.

Signature of Patient/Proposed Insured

Date

Signature of Witness

Date

Address of Patient/Proposed Insured: _____

Insurance Companies Authorized:
Transamerica Life Insurance, John Hancock Life Insurance, West Coast Life, ING Reliastar Life, Prudential, North American Company for Life & Health, Banner Life, AIG American General Life Insurance, Lincoln Financial Group, AXA Equitable Life Insurance, Lincoln Benefit Life, Genworth, Nationwide, New York Life, ANICO, Aviva and IBU.