



PETERSEN INTERNATIONAL UNDERWRITERS

23929 Valencia Boulevard, Suite 215, Valencia, California 91355

(661) 254-0006 (800) 345-8816 Facsimile (661) 254-0604

Website: <http://www.piu.org> E-Mail: piu@piu.org

AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION

This Authorization complies with the HIPAA Privacy Rule

I, _____ (Proposed Insured/Patient) hereby acknowledge this Authorization to Release Health Related information.

I authorize all Healthcare Providers that have been involved in my care, diagnosis or treatment which includes, but is not limited to:

Physicians

Hospitals

Clinics

Medically related facilities

Rehabilitation facilities

Laboratories

Other/Specific: _____

____ Proposed Insured/Patient Initials

to disclose my medical records to Petersen International Underwriters (or its assigned representative including, but not limited to: Secure Image Solutions) for the purpose of insurance underwriting or claims administration. For purposes of this authorization, medical records shall include, but not be limited to:

Patient Histories

Progress notes

Test results

X-rays

Psychiatric Evaluations

Drug and/or Alcohol Treatment information

HIV Test Results and/or

Other diagnostic information

____ Proposed Insured/Patient Initials

If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.

Signature of Proposed Insured/Patient

Date

Printed Name

Signature (if by someone other than the Proposed Insured/Patient)

Date

Printed Name and Relationship

I, _____ understand and agree that Petersen International Underwriters may disclose my medical records and the information contained in those records to third parties such as insurance companies or insurance underwriters, attorneys, or to representatives of such third parties (including reinsurers and information agencies) for the purpose as stated in the above.

I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy Laws.

I understand that I may revoke this Authorization, except to the extent that any health care provider or Petersen International Underwriters, has acted in reliance upon this Authorization. My revocation of this Authorization must be in writing to:

Petersen International Underwriters
23929 Valencia Boulevard, Suite 215
Valencia, California 91355

A copy of this signed Authorization is valid as the original. I have the right to a copy of this Authorization.

This Authorization will expire 2 years after the date the Authorization is signed unless a different date is specified here: _____.

If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.

Signature of Proposed Insured/Patient

Date

Printed Name

Signature (if by someone other than the Proposed Insured/Patient)

Date

Printed Name and Relationship