



PETERSEN INTERNATIONAL UNDERWRITERS
 23929 Valencia Boulevard, Suite 215, Valencia, California 91355
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 Website: <http://www.piu.org> E-Mail: piu@piu.org

AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION
 This Authorization complies with the HIPAA Privacy Rule

Name of Proposed Insured ("Applicant") _____ Date of Birth _____

I specifically authorize the following Healthcare Provider (name of provider) _____ in addition to all Healthcare Providers that have been involved in my care, diagnosis or treatment including, but not limited to Physicians, Medical Practitioners, Hospitals, Clinics, Medically related facilities, Rehabilitation facilities, Laboratories, Pharmacy, Insurance or Reinsurance Company, Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriter, or its assigned authorized agents/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 all health information pertaining to any medical history or physical condition and treatment received including, but not be limited to patient histories, progress notes, test results, X-ray/laboratory and other reports, psychiatric evaluations, drug and/or Alcohol Treatment, information and/or HIV Tests/Test Results, and any other pertinent medical information.

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 refuse to sign this authorization and that such refusal to sign will not be a condition to affect the ability of the Applicant to obtain treatment. 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.

 Signature of Proposed Insured/Patient

 Date

 *Signature of Legal Representative (if other than Proposed Insured/Patient)

 Date

 Printed Name and Relationship

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