Synchronize
Powered by Lockton Affinity

Authorization to Disclose Health Related Information

/ /

Patient Name (last, first, middle) DOB last 4 of SSN

I authorize the use or disclosure of the above-named individual's health information. The following individual or organization is authorized to make the disclosures requested for the purpose of obtaining life insurance:

Primary Doctor Name Phone Fax

Address City, State, Zip

Specialist Doctor Name Phone Fax

Address City, State, Zip

Information to be Released: All chart notes, biopsy and pathology reports, cardiac studies, lab studies, medication list, special tests with results and interps and all referral notes and recommendations
Dates of Service: ☐ Last 5 yrs ☐ Last 3 yrs ☐ From _____to Present

1. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2. This information may be disclosed to and used by the following organizations and re-released to the insurer(s) named below:

☒ Synchronize 12701 Whitewater Dr, Ste 200 Minnetonka MN 55343

☐ EIS Copy Service, PO Box 778 Torrance CA, 90508

☐ Release Point, 405 Foothill Blvd Ste 204 Claremont CA 91711

☐ JetStream APS, 1663 Sawtelle Blvd, Los Angeles CA 90025

American General, American National, Ameritas, Accordia/Global Atlantic, Athene, Assurity, Axa/Equitable Life, Brighthouse Financial, EP, Genworth, John Hancock, Legal & General America (Banner/ William Penn), Lincoln National, Lincoln Benefit Life, Lloyds of London, MetLife, Minnesota Life/Securian, Mutual of Omaha/United of Omaha, National Guardian Life, National Life Group, National Western Life, Nationwide, New York Life, Mass Mutual Life, North American, OneAmerica, owR Opinion, Pacific Life, Peterson International, Principal National Life/ Principal Life Insurance, Protective, Prudential, Standard, Symetra, Transamerica Life, Voya/ReliaStar Life, Sun Life Financial, Corebridge Financial, United Life (UFG Insurance), The Blueprint Insurance Services, Cincinnati Life, Integrity Life Insurance, SBLI, Security Life of Denver, Lockton Affinity LLC dba Lockton-Affinity Insurance Brokers LLC

3. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the company checked at the address above. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides insurer with the right to consent a claim under my policy. Unless revoked, this authorization will expire within 180 days from the date of my signature below. A photocopy of this authorization shall be as valid as the original.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the privacy officer at this facility.

Signature Date

Signature and relationship if not insured Date