



**AUTHORIZATION TO DISCLOSE & RELEASE
PROTECTED HEALTH INFORMATION
(HIPAA Compliant)**

Patient (Insured's) Name: _____

I, _____, the undersigned insured(s) (hereafter referred to as "I", "me" or "my"), authorize the disclosure of my protected health information ("PHI") as defined under the privacy regulations promulgated pursuant to the *Health Insurance Portability and Accountability Act of 1996* ("HIPAA") as follows:

1. Classes of Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (each, an "HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization.

2. Release Authority: I specifically authorize and request any HCP receiving this document to rely upon an original or reproduction (photo-static, facsimile, e-mail attachment, or other reproduction) of this authorization. I understand this release may be transmitted by **LIFE SETTLEMENT SERVICES, LLC**, to an Authorized Recipient or Designee via e-mail, computer disk, facsimile, photo-static reproduction, and shall also be considered the same as the original.

3. Classes of Persons Authorized to Receive My Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to **LIFE SETTLEMENT SERVICES, LLC**, to any life/ viatical settlement company designated by **LIFE SETTLEMENT SERVICES, LLC**, to any second opinion underwriting services designated by **LIFE SETTLEMENT SERVICES, LLC**, not limited to: 21st Services, American Viatical Services, A.M. Scott, Examination Management Services, or Fasano Associates, and/or to **LIFE SETTLEMENT SERVICES'** authorized representatives, successors, designees and affiliated entities, agents, subsidiaries, independent contractors, service providers and the officers, directors, and employees of each (each an "Authorized Recipient"). I understand that my PHI may be transmitted to an Authorized Recipient via e-mail, computer disk, facsimile, photo-static reproduction, via web posting to a secure website, or via FedEx, UPS, U.S. Postal Service, or any designated courier or delivery company or service.

4. Description of Protected Health Information Authorized for Disclosure and Purpose of Disclosure: This authorization shall apply to any and all of my health and medical data, information, and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all

