

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Instructions: Please complete form in its entirety. The release is not valid without signature and date signed by patient, guardian, or legal representative.

To disclose the following information from the health records of:

Name: (printed) _____

Address _____

Date of Birth _____

Information is to be released by:

Physician or Facility: _____

Address: _____

Phone Number _____

Information is to be sent to:

Western Catholic Union

PO Box 410

Quincy Il 62306

Information to be released – covering the periods of health care

From _____ to _____

LAST 3 YEARS

Purpose of request: needed to underwrite my application for life insurance

The following information may be released:

Complete health record to include clinic notes and progress notes, radiology reports, EKG reports and pathology reports.

I acknowledge that records to be released may include information that is protected by Federal and/or State law.

I specifically authorize the release of confidential information relating to:

AIDS/HIV/sexually transmitted diseases Behavioral health/psychiatric care

Treatment for alcohol and/or drug abuse

I understand that I have a right to revoke this authorization at any time. My revocation must be a written notification to my agent or to Western Catholic Union at the above address. Unless revoked, this authorization will expire one year from the date of signature.

I understand the information released may be subject to re-release by the recipient and no longer be protected.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment. However, I also understand that my application for insurance can be declined if I choose not to sign this authorization.

By signing below, I authorize my provider, identified above, to release my protected health information specified above.

Signature of Patient/Guardian/Legal Representative

Relationship to patient

Witness:

Date Signed