

### **AUTHORIZATION TO RELEASE INFORMATION**

Purpose: This Authorization is drafted to permit disclosure of health information consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

In connection with my intent to purchase a life insurance policy, I authorize any medical practitioner or facility or related entity, any insurer; employer; group policyholder; contract holder; or benefit plan administration to give the LeClair Corporation (aka "LeClair") or any third party acting on LeClair's behalf in this regard:

- Personal information and data about me;
- The entire medical file for the last ten (10) years, including medical information, records, and data about me, including information such as office visits, outpatient treatment, drugs prescribed, medical test results, and sexually transmitted diseases and similar information;
- Information, records, and data about me related to alcohol and drug abuse and treatment;
- Information, records, and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
- Information, records, and data about me relating to mental illness, other than psychotherapy notes.

This Authorization will expire twelve (12) months from the date on this form. I understand that, unless permitted by applicable law, I cannot revoke this Authorization if LeClair has already relied on it, and those actions taken by LeClair prior to their receipt of revocation will be deemed valid. Revocation may be the basis on which LeClair ends their efforts to help me obtain life insurance coverage.

By signing below, I acknowledge my understanding that

- All or part of the information, records, and data that LeClair receives pursuant to this Authorization may be disclosed to and used by any insurer, reinsurer, employee, affiliate, or independent contractor who performs a business service for LeClair in connection with the prospective life insurance application
- Medical information, records, and data that LeClair receives may lose certain protections under existing federal laws and regulations covering privacy and confidentiality
- Information relating to HIV test results will only be disclosed as permitted by applicable law;

A photocopy of this form is as valid as the original form.

\_\_\_\_\_  
(Printed name of applicant)

\_\_\_\_\_  
(Date of birth)

\_\_\_\_\_  
(Signature of applicant)

\_\_\_\_\_  
(Date of signature)

<b>Agent Information</b>		Date of IR Request:
Name:	Phone Number:	E-mail:
Fax Number:	Affiliation:	Best Time to Contact:

<b>Client Information</b>			
Name:	State:	Gender:	M / F
DOB: ___/___/_____	Height: Ft:_____In:_____	Weight:_____	Tobacco Use:
Type of Policy:	Length of Policy:	Face Amount(s):	
Riders Wanted(s):			
Has the Client Applied for Insurance?: Y / N		Has the Client Been Declined Coverage?: Y / N	
Health Issues (If any please give date diagnosed):			
Current Medications:			
When completed fax to 651.735.9883 Attn: Matt Barnsley			

Date diagnosed:	Circle One:    Type 1            Type 2
Is diabetes under control:    Y/N                            If yes, how long:	
What treatment/management was received or is receiving:	
Last Glucose and A 1 c score (MANDATORY) Please provide dates of scores: Glucose: _____ Date: _____    A 1 c: _____ Date: _____	
Any conditions caused by the diabetes? (Circulation problems, HBP, etc...)	
Regular checkups with doctor:    (If yes, provide dates of most recent)	
Y / N	
Is last urinalysis available:    Y / N	
Other Information?	