LEVEL FOUR®
Insurance Agency
A DIVISION OF
CARR, RIGGS & INGRAM CAPITAL, LLC

Authorization for Release of Medical Information

I, _____ authorize any life, health, annuity or disability insurance company, their reinsurers, Insurance Support Organizations such as Medical Information Bureau, Inc. and/or Consumer Reporting Agency, health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Level Four Insurance Agency and its employees and those persons or entities providing services to Level Four Insurance Agency. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted disease. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements that I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, life, health, annuity or disability insurance company or other health care provider to release and disclose my entire medical record without restriction.

The protected health information is to be disclosed under this authorization so that Level Four Insurance Agency may:

1) assist in the underwriting of my application for coverage, including eligibility, risk rating, policy issuance and enrollment determinations;
2) conduct other legally permissible activities that relate to any coverage I have or have applied for with the insurance companies named below.

Accordia/Global Atlantic
Advantage Insurance Network (AIN)
Allianz
American General
American National
Ameritas
Assurity
AXA-Equitable
Baltimore Life
Cincinnati Life
Foresters
John Hancock
Life of the Southwest
Lincoln National
Minnesota Life/Securian
Nationwide
New York Life
North American
Pacific Life
Penn Mutual
Principal Life
Principal National Life
Protective
PRUCO Life Insurance Co
Sagicor
Symetra
Transamerica
United of Omaha
Zurich
Other: _____

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Level Four Insurance Agency, 12400 Coit Road, Suite 700 Dallas, TX 75251. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that the company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to their authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical records, Level Four Insurance Agency may not be able to process my application. I acknowledge that I will receive a copy of this authorization upon my request.

_____ _____
Printed Name (Proposed Insured) Date of Birth (Proposed Insured)

_____ _____
Full Address (Proposed Insured) Social Security # (Proposed Insured)

_____ _____
Signature (Proposed Insured *or* Personal Representative) Date

_____
Description of Personal Representative's Authority/Relationship to Proposed Insured

082222

Primary Insured Information

Physician's Name	Specialty	Phone
1)		
Address	City	State: Zip:
2)		
Address	City	State: Zip:
3)		
Address	City	State: Zip:
4)		
Address	City	State: Zip:
5)		
Address	City	State: Zip:
6)		
Address	City	State: Zip:

Last Doctor Visit: _____/_____/_____ Reason/Treatment: _____

Last Hospital Stay: _____/_____/_____ Reason/Treatment: _____

Surgeries recommended but not performed: