Authorization to Release Medical Information for Disability Insurance

Patient Information

Full Name

Date of Birth

Address

Provider Information

Doctor or Medical Provider Name

Provider Address

Insurance Company

Insurance Company Name

Insurance Company Address

Authorization

I hereby authorize the above-named provider to release to the disability insurance company identified above any and all medical information relevant to my disability insurance claim. I understand that this information will be used solely for the purpose of evaluating my eligibility for disability benefits.

Specific Information to be Released (optional)

Purpose of Disclosure

Disability Insurance Claim

This authorization is valid for one year from the date signed unless revoked earlier in writing. I understand that I have the right to revoke this authorization at any time by notifying the above provider in writing, except to the extent that action has already been taken in reliance on this authorization.

Signature

Date