Authorization to Obtain Personal Health Information

For Disability Insurance Claim

Name of Insured:

Date of Birth:

Policy Number:

I hereby authorize the following practitioner(s) / hospital(s) / health care provider(s) to disclose my personal health information:

To the following insurance company/representative:

Specific information to be disclosed (e.g., reports, history, test results):

Purpose of disclosure:

Disability Insurance Claim

I understand that:

- This authorization is voluntary.
- I may revoke it at any time by submitting a written request to the insurance company, except to the extent that disclosure has already occurred.
- This authorization will expire one year from the date signed below, unless otherwise specified.
- A photocopy or fax of this authorization is as valid as the original.

Signature of Insured:

Date:

Name of Representative (if applicable):

Relationship to Insured:

Signature of Representative:

Date: