P.O. Box 3211
Milwaukee WI 53201-3211

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414-223-3201 Fax
800-927-2547 Toll-Free
catholicfinanciallife.org

For overnight delivery use 1100 West Wells Street, Milwaukee, WI 53233

Authorization to Obtain Medical Information

Insured:

Insured's Name ______________________________ List all names by which the insured may have been known, including maiden or hyphenated name or nickname, derivative form of first and or middle name or an alias.

Insured's Address ____ Date of Birth _________________

City __________________________________ State _____ Zip __________ Social Security # _____________

Medical Provider:

1. Physician/Facility Name____
   Address ____________________________________ City _____________________State_____ Zip_________
2. Physician/Facility Name____
   Address ____________________________________City______________________ State_____ Zip_________

I, the Insured, hereby request and authorize the Medical Provider (listed above) to give to **Catholic Financial Life**, its legal representatives or its records collection agent, any and all medical and non-medical information about me, and/or my minor child (only if the child is the insured) for the period starting on ___________, to the present and up to two years beyond the date of this authorization.

I understand that the information to be disclosed may include diagnosis or medical history, treatment or prognosis of any physical, psychological, psychiatric and emotional illness, drug or alcohol abuse, communicable or venereal disease, Acquired Immune Deficiency Syndrome, HIV testing, Hepatitis A, B, C and sickle cell anemia.

☐ History and physical ☐ Consultation reports ☐ Doctor/Clinic progress notes (except psychotherapy notes)
☐ Hospital records ☐ Discharge summary ☐ Surgical reports
☐ Laboratory & X-ray reports ☐ Pathology reports ☐ Other__________________________

I understand that Catholic Financial Life will use this information to determine eligibility for benefits being applied for on the life insurance. Catholic Financial Life will only release this information to organizations performing business, insurance or legal services for Catholic Financial Life in connection with this application or claim, or as may otherwise be lawfully required. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) rule.

This authorization shall remain in effect for two years from the date shown below, unless revoked earlier. This consent may be revoked at any time upon written request executed by the undersigned and directed to Catholic Financial Life, 1100 W. Wells St., Milwaukee, Wis. 53233. Such revocation will have no effect on actions already taken by Catholic Financial Life or its authorized agents. Health care and payment of health care will not be affected if this authorization is not signed.

I agree that a photographic or faxed copy of this authorization shall be as valid as the original. I (or my authorized representative) have the right to refuse to sign this authorization. However, Catholic Financial Life may refuse coverage or payment of claimed benefits if this authorization is not signed. I (or my authorized representative) am entitled to receive a copy of this authorization form.

Insured's Signature ____ Date____________________________
(Parent or guardian, if insured is under age 16, or authorized representative)

Relationship to Insured *(if not signed by Insured)* _______________________