AUTHORIZATION FOR RELEASE OF INFORMATION
SUBROGATION DEPARTMENT

1. **I (the undersigned) authorize** any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; insurance or reinsurance company; government agency; department of labor; group policyholder; employer; policy or benefit plan administrator; or any party to this accident/injury to release information from the records of:

Claimant/Patient Name: _____
(Last) (First) (Middle)

2. Information to be released: Data or records related to the accident or injury in question.

3. Information to be released to: Claims Administrator
17475 Jovanna Drive
Homewood, IL 60430

4. I understand the information obtained by use of this Authorization will be used by the company to evaluate my claim. The Company will only release such information:
   a. To other persons or organizations performing business or legal services in connection with my claim(s); or
   b. As otherwise may be required by law or as I may further authorize.

5. I further understand that refusal to sign this Authorization may result in a delay in the determination of benefits.

6. I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

7. I understand that I may revoke this Authorization in writing at any time, except to the extent:
   a. the Company has taken action in reliance on this Authorization; or
   b. the Company is using this Authorization in connection with a contestable claim.

8. To initiate revocation of this Authorization, direct all correspondence to the above address.

9. A photocopy of this Authorization is to be considered as valid as the original.

10. I understand I am entitled to receive a copy of this Authorization.

Signature: _____ **Date:** _____

Claimant/legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/patient is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

Print Name: _____

Relationship to Claimant/Patient or personal/legal representative signing for Claimant/Patient: _____

Address: _____ Phone No.: ( ) _____
(Street)

_____
(City) (State) (Zip Code)

800.843.3831