LIFELONG MEDICAL CARE
AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize:

Name of Disclosing Party

Address

City State ZIP

Phone # Fax #

To disclose to:

Hoosier Services Inc.

Name of Recipient

18032 Lemon Drive, #C-618

Address

Yorba Linda, CA 92886

City State ZIP

800.882.4156 800.882.4957

Phone # Fax #

Records and information pertaining to:

Patient Name/ State Previous Names		Date of Birth		Social Security Number
Address	City	State	Zip Code	Phone Number

For the following purposes: Life Insurance

This authorization is in effect until ______________________ (Date or Event), when it expires.

Specify Records: Check the box, initial and/or sign to specify which type of information is to be disclosed.

CHECK ALL THAT APPLY:	SIGN or INITIAL
☐ MEDICAL INFORMATION	
☐ PSYCHIATRIC INFORMATION	
☐ DRUG/ALCOHOL INFORMATION	
☐ HIV TEST RESULTS/ INFO	
☐ GENETIC RECORDS	
☐ OTHER HEALTH INFORMATION (specify below)	

Specify the records to be disclosed: ______________________

I UNDERSTAND THAT BY SIGNING THIS AUTHORIZATION:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Date | Patient/Client/Legal Representative Signature | If Signed by Other than Patient/Client Indicate Relationship

A copy of this authorization is as valid as the original. Client/Patient has a right to a copy of this authorization.

IDENTIFYING INFORMATION FOR PERSONAL REPRESENTATIVES

COPY OF IDENTIFICATION IS ATTACHED TO THIS FORM : Yes ☐ No ☐

TYPE	(CA DRIVER'S LICENSE, CA DMV)

IDENTIFICATION CARD ☐ BIRTH CERTIFICATE ☐ BENEFITS IDENTIFICATION CARD ☐
MANAGED CARE CARD ☐ STATE OR FEDERAL EMPLOYEE ID CARD ☐

IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.

NOTARIZED BY: ______

ON: ______	(DATE): ______

NOTARY PUBLIC NUMBER: ______

NOT OFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

PERSONAL REPRESENTATIVE INFORMATION

WHAT LEGAL AUTHORITY DO YOU HAVE TO MAKE MEDICAL DECISIONS FOR THE PATIENT?

PARENT ☐
GUARDIAN ☐
MEDICAL POWER OF ATTORNEY ☐
CONSERVATOR ☐
EXECUTOR OF WILL ☐
OTHER ☐