MIKE LOVE
INSURANCE MARKETING
EST. 1977 | LOS OLIVOS, CA

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility or any other healthcare provider that has provided medical care to me or on my behalf within the last 10 years to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to **Don Love CLU Agency, Inc. dba Mike Love Insurance Marketing** ("Representative"). In addition, I hereby authorize the Representative to disclose my personal financial and health information to the insurance companies listed at the bottom of this page and to insurance agents and brokers acting on my behalf.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the procurement of life, health, long term care and other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed at the bottom of this page, their reinsurers, as well as the Representative's staff and employees.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to a copy of this authorization.

I understand that I may write to the Representative at PO Box 758, Los Olivos, CA 93441 to revoke this authorization and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and the revocation will not affect those actions. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information. I understand and acknowledge that I will receive or have received a copy of this authorization.

I understand that my healthcare providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

_____ _____
Proposed Insured's Printed Name Date of Birth

_____ _____
Proposed Insured's Signature Date

_____
Agent/Witness Signature

American General Life Insurance Company, American National Insurance Company, AXA/Equitable, Banner Life Insurance Company, GFSC Inc. dba The Chittendens, Genworth Financial Companies, John Hancock Life Insurance Company, Lincoln Financial Group, Minnesota Life, Mutual of Omaha Insurance Company, North American Company for Life and Health, Pacific Life Insurance Company, Peterson International Underwriters, Protective Life, Prudential Financial Companies, Standard Insurance Company, Savings Bank Life Insurance Company of Massachusetts (SBLI), State Life Insurance Company, Transamerica Insurance Company, United of Omaha Insurance Company, VOYA Financial.

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